NATIONAL QUALITY FORUM

Moderator: Reva Winkler
April 1, 2014
10:44 a.m. ET

Reva Winkler: Good morning everyone. Thanks for regrouping this morning. We're still waiting for Ernie but he'll catch up.

So, after you all left and I hope you all had a pleasant evening, the weather was really nice and a good dinner. We tallied your – the results for your prioritization exercise from last night. Where do we put them?

Nope.

No. Yes. So, where are the – OK.

Here's how you prioritize your short-term and really the pregnancy influence rose to the top, very, very prominently. The next level of priorities are around on you know, the HPV measure and then the diabetes composites measure.

And so, I think you do have pulled together a way of prioritizing the ten measures. We will present the (ten) as all priorities but again with some prioritization of where maybe to start first. So, that was the short-term.

And the long-term I think you were considering some of the issues around data and this is the, you know, composite measure of the immunization with other preventive services which we may take a little bit of methodologic work to pull that together as well as the healthcare personnel all recommended measures. So, followed closely by the diabetes composite again.

So, there's definitely some theme …

(Off-mike)

Female: We'd asked you …

Male: It's a theme measure, right?

So, regarding for the theme measures both in the short-term and long-term?

Reva Winkler: Right. And as a way of looking at them, you know, some measures may have, you know, some more considerations around the methodology development, data source development, so that they might be hard to do in the short-term but they're still priorities.

Male: I get it. I get it.

Reva Winkler: So, we use the same list, but essentially I think we can see that there, you really have coalesced around some, you know.

Male: Yes. I guess you could have said we could have split the list into short and long-term …

Reva Winkler: Yes. That would have been a way to do it too.

So with that, is everybody comfortable that this really represents your thinking?

Male: If we can just go back to the long-term again or (inaudible) like kind of the way that (inaudible).

Male: So, I actually, you know, the way I looked at this was actually, I put a short-term thing to that so we're immediately ready to go because we have no issue with the science. We have no issue with data. So I immediately had diabetes and had pregnancy right up there.

So my broader long-term concept was that those were in many ways that we do composites from those two. They would eventually slide into that long term composite measure for adult immunization, because remember how we

talked about the composite measure being including immunizations with adult immunizations preventive services and then we would have the sub population, special populations that I looked at, you know, while we could do this special populations first because we have – we have the date on that. And then, when that long-term composite comes around, eventually we could all apply that into some – into that framework. And that's kind of how I envision (inaudible). But I don't know if that's how people thought of it, because I think there's obviously some focus on variation there.

Female: Looking well, I think.

Male: You and I are thinking very similarly LJ. You know, the other reason …

Male: You know that's my thought as well. OK.

Male: The other reason is that actually thinking about risk, stratification, probably those at high at risk are those in a special population. So you really will get more immediate bank for your buck as well as the other thing.

Right. And I think also it's more – it would be more easily acceptable and I think people will get it much more quickly than I think they will the general population measure.

Reva Winkler: I've heard everything you'd have to say and trying to write that up will be interesting. So, I will be calling on you to help us figure out how to describe that for a general audience to capture the essence of what it is we're trying to say. So, you will definitely be an important part of being sure how we frame the message and wordsmith to convey exactly what we're trying to convey, because I do think that that concept is a little bit complex that we should be able to figure out a way of describing it to get it across to folks.

But other than that any other thoughts?

Roger Baxter: Well, I found the long-term, short-term thing. It was like throwing at the last second and I hadn't even thought of it before hand and I really didn't have time to think about it before we voted on it. So, really it didn't mean anything to

me. I wasn't able to think as fast as LJ was. So, I didn't – I wasn't able to really do it that way. I had – I would have had to sit down and think about it.

So, I just put them in order of what I thought was more important to me. I thought in our discussions that there are other things that came out there were more important to us. We seem to think that some of the data issues were actually more important than having new measures. And I thought that there was a lot of thought and talk about not just creating new measures for having new measures which in the end it kind of seem like we did. We just said well, we're going to make four new measures period. Two short and two long.

After all that it seemed a little unusual to me. Because I thought we'd identified that all this, you know, consolidating and harmonization was probably more important than coming up with new measures.

And then, I think we'd also identified early in the meeting that we weren't sure about data that there was bigger problems with getting data than there was with actually needing new measures.

Male: I think you're right Roger. That's exactly what we talked about. But it's – I think we also have to consider what is actionable, you know, I mean as much as we'd like to be able to make some recommendations about what needs to happen. I think we can be more impactful if we make recommendations around measures and what can be developed given what's available. So, I don't know. I think this is the right focus.

At the end of the day what we'd like to – you're right. The harmonization thing was a big focus point and some consolidation would be some nice recommendation that we could make that would be actionable but this I don't think that we can expect a lot after making recommendations for how to connect from data.

But the long-term recommendations would naturally come from this.

Male: You know, Roger that's what my understanding is. That's a clarification question for Reva. I think at the end of the day we're still going to come up with a recommendation. I mean this is just going to fit in those

recommendations and just we talked about last night is we're going to talk about consolidation and harmonization, right Reva?

Reva Winkler: Yes, actually when we're, you know, finished going through this, I had a couple of these sort of additional consideration topics. And then, we're going to break in to a couple of groups to focus and have, you know, sort of focus casual conversations that you could come up with those kinds of recommendations and then come back and see if the co-group wants to buy them and add to it.

I see the report out from this group to be the measure gap which was the objective of the project as well as the recommendations that support it that look at the entire frame.

Any other thoughts on where you landed?

Sure.

Thought Jim? Sure.

I mean it is interesting that really there does seem to be support around certain measures rather than other even though during the discussion yesterday all of these 10 came up as being important.

Male: The question I have is that if you know after three people who voted for composite measures in short-term and now seeing that in the long-term, where would they move their votes?

Female: I don't understand your question.

Male: Because you got three people who voted for the composite measure, then short-term. And we have it as obviously the number one priority in long-term. Those three votes were now convinced that that's a longer term (inaudible).

Female: So, why would they do it …

Male: Why would they do it at three votes? Because that could change the ranking for diabetes versus HPV.

Reva Winkler: Right.

Male: And – but I'm getting a sense you're probably going to report out the …

Female: No. I mean report out ten. I'm just going to focus, you know, I'm saying the – yes. This would be start here first.

(Off-mike)

Reva Winkler: And so – All right again …

Female: I want to ask about the HPV. From 19 to 59 HPV, I didn't – I did not vote for that.

Reva Winkler: No, I mean.

Female: It's different though to people than the current speed of measure that's the 19 to 26th, what are we recommending here that …

(Off-mike)

Reva Winkler: Yes. We need to – well, I know. I know.

Female: I just think we already have a measure. So what are we recommending?

Reva Winkler: The measure that I am familiar with is for adolescence.

Female: Yes.

Female: OK. Yes you're right, sorry. That's …

(Crosstalk)

Female: You're right. You're right, there is on the catch-up one. I think they're …

Male: I was ticking myself because NVAC actually gave official opinion to that and they added boys because …

Female: Yes they added boys. Right. Right.

Male: They (inaudible) to get that happen. But I totally forgot to have them extended the 26th.

Male: Yes that's right. I'm thinking about the discussions that we had.

Reva Winkler: Yes and obviously I need to just change those slides. It was because this was part of the age group of 19 to 59.

Female: And if male and then female, as there saying on this post.

Female: OK. That's clarifying, making sure we all assume that's (inaudible).

Female: Yes.

Reva Winkler: OK. All righty. Anything else? I mean again, you're going to get a first look at once we draft the report with the recommendation as you all get a chance to look at it and review it and to be sure you would characterize it in the way that you're intending and we definitely are would want your feedback and suggestions. So you will see it before the world sees this.

OK. What we want to do today is those recommendations that Roger wants to talk about. And so, one of the things I had done some slides for yesterday that we didn't get to because we were having such a good conversation were a couple of these other considerations around performance measurement that may form the basis of some of these recommendations.

And so, the first one was again our issues around data sources, and this sort of is a crosscutting across all issues. And, you know, I just listed out here that the types of data sources that are currently in use for various measures. And as we've discussed in various ways, the availability of that data and equality of the data and data integrity is huge for quality measurement and is one of the major challenges.

And so, if there are, you know, potential recommendations around data given the conversations we've had, we certainly would want to include that because it is such a fundamental underpinning for measurement. Thoughts from anybody at this point?

Male: Well I think we've had lots of comments yesterday about the challenges of individual survey data. It would be nice if we all had to recall that 100 percent. But from a provider standpoint of the challenge of the abstracting, you know, pulling data from either paper or electronic records is a great one. But I think that if we're not doing something from the record ton pull some claims, it's going to be very difficult for us to get data, that's going to be a little while.

Male: Excuse me.

Female: I don't think that's necessarily permanently true for adults though. I mean a complete IIS would be a good source for geographic or population based data. I mean I think it's definitely the case now but like the direction that we're moving for childhood vaccination is to use IIS even for more of a population look so that might be a short term versus long term issue.

You know if you don't see a practitioner, you don't know how you get a record at all. But …

Male: Right. I mean that's my point. You – this – Many of the, all these preventive services are recommended for people whether they're sick or they're not sick. And so to get information about people who are – whether they're getting, you know, people get flu shots or go get a cancer screening mammogram even though they may not be on a regular basis seeing a clinician that's going to be critical information to capture.

Male: We have had some interesting validation work that we've done in my state over the last couple of three years looking at data from the child's immunization registry that's opposed to BRFSS, as opposed to chart abstract for our Medicaid kits. And the linkage between the data is very, very loose, very loose. It doesn't really track nearly as well as you would expect it to. And so while I think if we get to the point of having national registry, I think it would be wonderful.

I think that's clearly a long, long term rather than a short long term solution that will likely get to – for the adult data.

Male: And like Laura's comments yesterday and she's not going to repeating today. But she saw the future of data collection in the personal health record. And I think the bad (inaudible) probably is right. We have different kinds of providers all contribute to the positive vaccination and other preventive services. So I mean I think it's nothing that should be exploited.

And thank you LJ I checked out I mean that can be yesterday which was very interesting site, (inaudible) to some degree. And what's missing was the upload button. So if we have these apps and this centralized upload button and.

Male: How could to Canada on the development process on that and one of the things that was validation of the data because they got to figure a way to – because if I have that app and I could just upload my immunization records, how do you go get past the validation that I actually got my shot. And I think that's one thing that – so they got to – they want to be working on it but that, you know, they wanted to launch the app.

Male: No I like Laura's suggestion if you just do scan the barcode and have a conformation for a lot number. And then, you know, if you find people who may identify it's when you duplicate that and concern it on those expense and one in your account I guess.

Male: So the unique identifier …

Male: Seems like it's all feasible.

(Off-mike)

Female: And I don't think that it's all that hard to get to. There's a catalyst brand out that I happened to see when we're dealing with a bunch of grids that someone is looking at the ability to start to come, have the (decision) to the scanning into a central location like there in scanning in on your eye zone and you know, they can download it into some central registry.

And the importance I think is for the – you can get these measures obviously. But the other thing is that from a safety standpoint. I mean part of the biggest nightmare with H1N1 was figuring out what people had thought. And had we had the lot number and, you know, the specific vaccine that's going to (inaudible), we would have, you know, taken our safety database in much greater and more granular level which I think it's where we fire to these.

And I think that just putting – I think it's really important. But the (inaudible) burden whatever you want to call it responsibility back on to the patient. Because ultimately, we want them to get a sense of preventive medicine and taking care of yourself than it's you and you know, so I think it all goes together.

Male: The technology is definitely there. That's actually a part of a group in adolescent immunizations and there's a group out there called Paradox run by (Hesky) who is very – who are looking at a lot of this peer to peer validated communication and we had an expert from Verizon talking about it. The technology is out there, what the challenges is trying to figure out how to work on privacy and confidentiality issues with that kind of transmission of data. But it's definitely out there.

And I think once they take that next step and figure that out, you know, it's ones we're looking at obviously is how do you translate records back and forth between the school nurse and also specifically, we're looking at obviously commission granting by parents. Because it wouldn't be nice if a kid shows up in a school clinic and you could actually get permission to do treatments through a wireless technology or smart phone or something and be able to validate it. And so I think that's where we're looking for that.

And I think at the same technology is – would be very useful for registries eating data development as well. I think you're right, I think that where we're heading towards. I just, you know, I think Canada is going to get faster because obviously that socialize got – to get access. I think we're just going to be a little bit trickier that way. I just hope we get there so I can just (inaudible).

Female: I'm just wondering if you could tell us on examples of other electronic databases. Is that like CMS filling data? And kind of talk about some ideas …

Female: You know it's for instance when we were talking with the Indian health service say centralized all their data into a data base that they worked off for some of their other mandated quality reporting. So they take it from their medical record and create an electronic database of clinical data. So, and that's not unusual for some larger organizations. And so, that's really what I meant somewhat generic. It wasn't specifically one of these other things.

Patient registry might be another one. I was going to ask that question, you know, in terms of the patient portal for submitting information. And Roger, I'm wondering if Kaiser is doing anything in terms of a patient sending it to their medical record their EHR. I mean, that kind of technology, because we're talking about I think, you know, sending it to the registry, but sending it to their patient record which could also then go to the registry, but it would be nice if (inaudible) is on there too.

Roger Baxter: So, there's a lot of things that have change in technology now. So, a lot of our medical care is done by e-mail now. And those e-mails generated visits, right now they don't generate a diagnosis code, the codes that are used for telephone visits. We have a thing called a telephone visit that actually does generate codes. But just a telephone call that I make to a patient that I put in, it usually does generate code. Although, if I make a prescription, that'll generate a diagnostic code now.

So, there's a lot of very weird interesting things that are happening around medical records because of that. Patients can send things in, they can attach – they can send attachments to their doctor which can – and photos, so we'll often see photos of things we never wanted to see, open up the e-mails and these stuff you never could've dreamed of. Yes.

So, it is – I don't know, you know, (LJ) says, well, the technology is here. Sometimes the technology is here but it doesn't happen anyway. So, the technology is here for bar codes for vaccines. But our – the Epic, the group

that does the electronic medical record, they're not ready to do that. It's a simple table, but they say, well, maybe 2015 but we'll put it on our list, you know. And the way they are is that, well, if we do that for you, what should we take off of our list to do this one?

Male: There are actually systems out there to help in some of the meet for these measurements and they're out there for the provider. So, I think we're getting to a point where we can actually help the provider meet measurements which is nice. So, for example, I mean, when you talk about technology, there are a couple of vendors at least that I know of were creating stories and handling devices for vaccine. Essentially where the vaccines are managed entirely by a third party company or a physician's office, a practice or whatever, they're sparked by the vendors so the physician essentially has no liability or cause until the starting up or loss of acting inventory cause.

And what happens is that there's – the machine is hooked up to the internet to the vendor and also to the physician's EMR. And when you give a vaccine, what you do is you – there's a bar code scan right by the machine, you push the button, and you scan the patient's EMR. The machine logically figures out what vaccines are needed, dispenses the doses, you then scan the bar code, all of that goes right back into the EMR, feed directory into (CMS), feeds the record into the registry.

That's here. That's being piloted right now by two companies and practices across the United States. So, that will take away a lot of that entry into EMR, and your question I think the idea with meaningful stage three is that if it gets into its registry, it should feedback into EMR. So, hopefully, again, knock on words, you know, we're working in this transitional period where I think you already know is the 90 but we'll get there. And then, you know, then it becomes much easier for all of us.

Roger Baxter: Yes, the direct feedback looks different to the EMR for its essential. And pharmacists starting to figure this out as well. So, there's several startup companies that have been figuring out how to get pharmacy data to be directly into the registries. One that I'll mention that I think it's really interesting is run by the former secretary of health of Louisiana, a gentleman by the name of

Bruce Greenstein, started a company called (CTC). I'm not sure what that stands for.

But they directly – they form our connection (inaudible) again with the pharmacy to future (equity) in this, but the registry just so – and the adjudication process. So, it doesn't even have to be adjudicated as long as it's in the pharmacy just send in record, it will be directly into the state registry. There's a full (broom) EMRs from state registries, and that would – I guess, that would close that loop pretty nicely.

I'm a total skeptic for this stuff (inaudible). Tell him that it's going to be, right?

Male: Someone's got to do it, and I think what it is is that it's making it easy as adult providers to say, well, it's something to get measured and you want me to perform, you know, I can only do so if you help me move my burden on cost, an opportunity cost of having $100,000 with a vaccine inventory.

And the great news about this is (loss). I mean, because it's vended by a third party vendor, the machine is automated obviously into a cloud which meets with the vendor and the vendor can inform the provider meet point and you've got a temperature variation and you've got this going on as a practice (loss power), you know. And it makes it easy for that provider to do what he or she supposed to do and meet some of these requirements that we're asking (inaudible).

So, I …

Male: Get this – the privacy stuff that I'd feel kind of getting our way, that's all. And it seems like, you know, so that's what gotten the way of our joining the California registry and its privacy (inaudible) I'm just not sure that we give it over time those barriers. We put up the barriers, but it's pretty high.

Male: Yes, I hope we do.

Male: Yes, me too. If we can get around the privacy issues, I think that stuff can really work.

Female: I think there's the potential that it will actually get solved outside of the US – outside of using Canada, you know, because for a global maternal immunization platform, there's no way that that's going to work truly globally without some of these electronic IT solutions because, you know, it was just – they're not going to get people from – everybody has a (inaudible), but nobody has the (inaudible) gets in the top of the mountain (beyond) the health center.

So, there's lots of, you know, work being done all over Sub-Saharan Africa anyway looking at, you know, how you're going to use your, you know, iPhone and transmit data. And so my sense is that they're going to figure it out first or it at least will be, you know, tried there first and then, you know, to the fact and to the featuring on different way. But I think there's definitely people working on it.

And then to answer your question, I mean, I think, you know, our patients now coding in their history via the internet and then obviously when they come to the office, we have to verify it. But for the most part, I mean, people went to that (kicking) and screaming, "Oh, they know it's not enough, oh, they won't know what this means," you know, that's not true. You know, this is a very sadly generation at least some people that I'm seeing. Obviously, (searching) the elderly may be not so good.

But, you know, for young women, you know, the 20, the whatever year old, I mean, even like kids like live on WebMD, they know the language better than sometimes I know the language, and they all look it up. So, it's been interesting looking at what people's put into their medical records because that's fairly accurate, even for things where I thought they're not going to know what that means. Not so much, people look it up and obviously they (inaudible). So, I think there's a future.

Female: I do want to – the only problem is this has been a measure, and NCQA is one of our measurement (vehicles) and (inaudible). And we're going to measure this reading from the supplemental data collecting processes. A number of providers have reported service data, whether reported to disease or case

management clinician collected during health targeted quality improvement or any other data collection process acceptable only if a company by proof of service documents in the legal health record. And NCQA is very, very rigid towards health.

So, while it sounds nice to upload all these patient imported data, if we can't use this in measurements, we're going to be (inaudible) that our measurements are not going to reflect what people think they should. And we get in troubles a day with some of the disease registry stuff. But just a caution that we have to make sure that it syncs up with how we measure.

Female: Anything else on data sources? I mean, it's a huge topic and it just underpins everything about measurement. But as we go through the day and you want to generate these recommendations, this is certainly an appropriate area to do so. I'm not going to mention that.

Jeffrey Duchin: Good morning. Hi, this is Jeff.

Female: Hi, Jeff.

Jeffrey Duchin: Hi, how are you doing?

Female: Great.

Jeffrey Duchin: Sorry, I missed (inaudible) 30 minutes. So, my question is for those to prioritize the diabetes measure, what kinds of data sources are you envisioning or how – or is this sort of just motivational sort o indicator to get people to put together better data sources considering all the issues we've talked about with respect to hepatitis B vaccination and difficulties with documenting that pneumococcal, it's one of the very challenging vaccines we measure composite that was involved both for those and possibly other vaccines among diabetics who are newly diagnosed, another challenge for measurement. I'm just curious about for those who prioritize that, how they're envisioning that measure would be (inaudible).

Female: I think that that one dropped the long term, didn't it? I mean, I think that that, in my mind, that's why it was long term because I wasn't sure how you were

going to get the data, but hopeful that in one of these things that was from your last slide that, you know, something in the future will come up and that you'll be able to get it in a more reliable way. But I think, in my mind, I wasn't interested in putting anything on the short term that wasn't going to be able to be realized.

Male: But I don't think – I think there was an artificial constraint with this long term, short term thing because, I mean, it's came up third and it was – the number of votes and – I mean, we just artificially picked two short term, so I don't know that it really – that people didn't like it. It seemed – maybe I'm wrong.

Male: I don't think it's an issue of liking it. It's – so, when we do our measure development process NCQA, we're working with workgroups or consensus based organization and a lot of people have some really great ideas about what should be measured, and then we go through this laborious process of building up the measure concept and then, quite frequently, those end up being – remaining as measure concepts which just is on a (shelf) because when our quality measures expert panel reviews and say, "Hey, the data is not there." So, you guys are going to have to just sit patiently while we refer that and that may very well be the case for any and all the measures that we provide or prioritize.

Female: I think Laura mentioned yesterday though that at times, if there is a high priority around the measure that maybe isn't feasible immediately, there is enough of a – you can generate enough support to find the answer. I mean, you may costly having to push because if you just stay where you are, you'll never go anywhere. So, you do have keep pushing those edges. So, what may not be doable today maybe much more feasible tomorrow or maybe only a few today and more tomorrow or something along those lines.

So, we factor all those things in.

Male: But Jeff was asking about, you know, how did we see this working. And I think, you know, people do identify diabetics in their practices and it seems like it is an actual gap. I mean, I know in our system where you'd think, you know, we have a registry. Everybody is a diabetic. It's all over the place but

they definitely don't get their Pneumococcal vaccines and they definitely don't get their hepatitis B vaccines.

And I don't actually know why, so a measure like this would actually help us move it forward and it's – we're a system that actually has a data and could do it. So, I – it seems like one that actually would work for us, although I didn't put it behind the list either, but anyway, so I was, you know, Jeff was asking – I think he was saying can we – do we have data sources for this. So, I certainly know that we do in our big system, but I think that other docs in the private community, they know their diabetic patients.

It doesn't seem like it's too forever stretched to me to identify a special group like that. Is that wrong? It seems like you can identify that.

Female: OK. We think (inaudible). It just as it followed on, we were talking about the registries and IIS, and so these were just some of the issues raised and some of the conversations we had with folks in our key informant interviews. So, I just – again, one of the small groups (inaudible) delve into, you know, this whole thing of immunization information systems but particularly as it relates to EHRs, you know, what's happening around the meaningful use program and specifically the development of eMeasures which are really not just measures converted to be used in EHRs but eMeasures are best done to Novell with plan for EHR implementation using the unique characteristics of EHR. So, retooling existing measures has not been a particularly successful strategy (for command) with eMeasures.

But being the people who really understand how they've been to work in their very unique characteristics. And when we were talking to (Chair Nielson) at (inaudible), one of the things she said was, you know, you could use the same set of data in your EHR to do a bunch of things, you know, inventory management, performance measurement, you know, disease management, a lot of different things. So, if you think bigger and think strategically and not just think quality measure, your EHR could potentially be a much more powerful tool. So, approaching it from that perspective rather than just the quality measure to be done in an EHR does have some real advantages.

So, again, whether there are any recommendations you might want to make around immunization information systems because yesterday if you recall, there were some discussion around potential measures associated with it. You really didn't want to go there but would default more to recommendations. So, we will, you know, see if there somebody would like to put forward for this.

If you wanted to go to the next one, next one that's where (inaudible).

Another area, very important that underpins measurement and one of NQF's big priorities is really never forgetting about potential disparities. Measures are one of the avenues for identifying disparities. I just pulled up this as an example. CDC, I think, when you publish all of the various national data very commonly will stratify the data by race and ethnicity. And in developing measures, it should always be a consideration. Not all measures or all topic areas benefit from doing something special that might address disparities, but there are some topic areas where it becomes very important.

And so – and recommendations around how measures for adult immunization should treat disparities and whether to include them in all of the measurements or not would be an important recommendation from this group to support measurement for adult immunization. So, I ask you to consider that as you're thinking about additional recommendations.

This was one I think you brought up a lot. Harmonization and I'll add consolidation. It's the first time I really heard that word used a lot and I think completely appropriate that we may have coined a new one going forward.

After the webinar, Roger asked about the impact of the results of a project he worked on with us back in 2008 where CMS asked us to look at fluent pneumococcal immunizations particularly addressing the issue of harmonization because even back then, there were still masses number of measures. We still got too many.

At that time, the goal was, you know, can we develop a single global measure that can be applied in all settings and providers so that, you know, everybody just measures the same thing the same way and we're done. There's a

resistance to doing that because of the different data sources. So, every different data source wants to have its own measure. You know, that may be more semantic that anything, but I think the concept of if you're going to measure flu, there's one way to measure it. And, you know, use your data source appropriate or however you need to do that.

But I think we hear over and over that multiple measures, as we've seen in our environmental scan, just create confusion and implementation. I – some of Dr. Nace's comments about, you know, it just – it's frustrating to providers and this is an area that's probably it's brought with this chaos as any.

So, what harmonization is is it aligns the measure construction specifications so that you're measuring your vaccination the same way.

And go to the next slide.

And this is one that you probably see (inaudible). This comes straight out of that report. Because there are different measure construct of how you put the numerator and the denominator together. The question is, you know, what do you do with your conclusions, what do you do with the – what do you do with the patients who refuse this? Well, you know, the provider did the right thing when the patient refused. Do they get credit for, they're being pulled out of the denominator. Well, different measures do different things. And if everybody is doing something different, we don't know what the result means, certainly the results are not comparable.

And so, this is just a really, you know, a straightforward example and where you've got two providers and, you know, what is the difference in the information depending on how the construct of the measure.

The first one is where you include patients were given the vaccine. If they refuse it, you include them in the numerator for credit for the provider. And if they have a contraindication, you include credit to the provider so that the overall provider did the right thing with 82 percent in both providers.

But if that's all the information you got, you really don't know very much. You know what the provider did the right thing but if you look at number two,

the numerator categories, this is just information that's part of the measure report so that you don't, it's not just a single data point.

And so if you look at these to providers who have the same measure results, you can see that their performance is quite a bit different in terms of the number of patients who receive the vaccine, the declining, now that can be there. We know that there are regional and specific populations that do call us around, you know, vaccine aversion.

But then contraindications, you know, of different provider's perception of what the contraindication versus another. And so I think that despite the fact that on the measure they would perform this.

There is more rich information with the numerator category so this was what was proposed in the projects that we did in 2008.

And after our webinar, we went through all these endorsed measures and sent you a list of those that's now conformed to that measure construct.

And essentially, all the CMS facility programs, hospitals, nursing homes, home health, and they expanded the nursing home (inaudible) to include you know, (inaudible) the nerves and you know, all those sorts of folks, as well as the healthcare worker and that's where (Megan) and I, we worked on.

And so they are all around that construct. What are not are you know, the (inaudible) measures because they're surveyed. Well, they are of a portion. They just haven't – they don't get rid of the declines or the contraindications anywhere. They just don't get counted. So it's not that they're unaligned, they're just, you know, all they're looking for is vaccines.

The outpatient measure however has denominator exclusions and exceptions to close those out of the denominator.

So again, we'd have a bit of a mixed bag of how this is being measured. So this is the harmonization, is a really important tactic to really try and make some sense out of the chaos and big bubble.

So if I know you've already done talking about harmonization and consolidation, so one of our groups is going to talk about that. So it would be really great to have some recommendations.

As you can see on the third option, when you start pulling your exclusions out of the denominator, your measures, you know, your results go all over the place. But also you lose track of some of your patients, you know. If they're excluded, you don't even know what happened to them they're gone out of the data. So that's another issue to consider.

So that's the harmonization and I think it seems like well given your conversations, we're going to see some recommendations.

Male: I have a question about this. So what else, it seems to me that there may be circumstances in which you don't want harmonization? So for example if you're trying to measure how well the quality of care, how well providers are performing, you might look at it one way. But if you're interested in the public health, in fact, and heard immunity and so forth.

Reva Winkler: And I think that's perfectly reasonable. I don't think that's inconsistent because I think that if you're talking about asking, do the provider do the right thing then you wanted some.

Female: But if you want to know how many patients got vaccinated, you want to know that particular sub number. And that's why maintaining your data with all those subsets is really the measure construct then you have a lot of flexibility on what you do with it.

But if all your report is the end, the 82 percent.

I guess I was talking too much.

So, but you're absolutely right because I think that those two perspectives are perfectly logical and by keeping a measure construct that allows you to maintain your data that way, you can do both.

Male: Also, you need transparency so it's quite given.

Female: Yes, exactly.

(Crosstalk)

Male: If I was working on the reference from this group, I think it's also a point to cross over and talk about this in the registry. So to make sure there is a communication, the recommendation or communication between different registry data collection because you need – if you want those numerator categories, they need to be explicitly asked for in the data collection by registries.

Otherwise, we're going to move with all that and if you go in later and say, well, if there's now at HL7 251, I mean we got to be there. Those (inaudible) have got to be ready to be answered.

Male: Registries, collect that data?

Female: We do collect the data. The person summing it, HL7 or uploading it have to know how to submit it and it's a more complex process and just (inaudible) just haven't (inaudible) the comments are.

(Off-mike)

Female: (Inaudible) that's right. So correct me if there's suddenly an educational component along getting that data absolutely in your registries.

Male: It was a protect – there's not like a box and check (inaudible) decline or …

Male: Our registry has certain codes so I think if it's age 5, it means the patient declined influenza or D2 means they had a medical contraindications.

So that's how we code it. I don't know (inaudible).

Female: Oh, the health (inaudible) registry does not collect, it's the only thing we would collect, would be the school exception requirement for this childhood rates so we have a couple of (inaudible) trying for the school and those are clearly check box on the field, but there's no – there's not even a free tech from (inaudible).

Jeffery Duchin: Hi this is Jeff. The registry piece is clearly important to my understanding is that significant challenge with the registry, is that they are no standardized in the way they collect data and their interoperability.

And I guess it's worth thinking that registries are going to be an important piece of total immunization quality measures. We might want to speak to that although I know there are multiple other groups and consortium sort of trying to grapple with this problem.

So right now, a lot of people, type registry is sort of going to be the answer to all of our data needs problems. But it's very difficult to get them to speak to each other (inaudible) jurisdictions even and there haven't been accepted national standards for data elements and how to collect information in these registries.

Male: Actually, that's perfect. Jeff that's exactly what I was trying to say and you did a much better idea. The other things I would like to say if we could also proactively on the recommendation that says that, you know, that thinks and I'm not enough of a (inaudible) to be able to say this right but there's probably a way to as new data fields come up because of measurement developments, there's got to be a way to standardize the way that process can feedback into registry so that that data collection can happen seamlessly.

I don't know how that can be done within the HL7 2.5.1 standards but we need to – I mean if we can't, then we need to proactively recommend that kind of future thought process.

Female: I think that the era group, the association of registries is working on that. I think they do have a certain standard data set but I don't know if it's optimized to collect the depths of data that we'd be looking for new quality measurements.

Female: Just another thought because we're talking about something that's going to evolve overtime, is you know, the registries I think were designed to collect immunization that occurred. And so that's the public health side of things.

But particularly around meaningful use in the increased use of the EHRs, you're seeing that providers have electronic data that's accessible.

And when you're looking at the quality and performance at the provider level, you know, perhaps it's using that EHR data, you know, might be the first avenue rather than the registry because EHRs are going to be used for quality measures. They're not just immunization but a whole raft of topic areas.

And so that hopefully these kinds of contraindication in the clients and those sorts of things, you know, might be better housed appropriately as part of the picture, this medical record and the measurement can occur at that level while we're waiting for everything to become more and more sophisticated and interoperable.

But we still have to recognize that you think one EHR …

(Crosstalk)

Male: And even more granular than that, you've seen one epic implementation, you've seen one epic implementation, not the ..

Male: And the compliment is that all of you see, with adult immunizations, we have providers that don't always have access to the patient's EHR. So that's the challenge as well. First, the registry may then be the only place where that gets documented.

Male: I was going to suggest that there is a parallel in another part of the health system. Now, there are some organization called CAQH, the Council for Affordable Quality Healthcare that has convened standards development organizations, providers and data vendors to create voluntary consensus standards that were then adopted into ACA for transactions between providers and payers. So perhaps as a long-term plan, you could make a recommendation for maybe at the registry's association that convene stakeholders to create voluntary immunization registry standards that would allow for all of this back and forth, and then overtime potentially those could be considered for legislative or statutory activity that would really get you to that kind of standardization eventually.

Female: So that was harmonization what was next (inaudible).

Again, I think it's been brought up a measure burden in something that you need to consider. Burden is a couple of different things. It's data, it's workflow, it's respond, you know, responding to the feedback that the measure gives you. It's building teamwork in your patient centered medical home. So there is a lot around burden to think about so that never want to forget that you could measure everything and you would be buried under the weight load of it all.

So it's important that's why the focus of these efforts have been around prioritization and really focusing so that we don't overburden an already burdened system as I think some of you very eloquently discussed yesterday.

So, I mean I wanted to be sure I focused in on that so right, this slide is for you.

Male: And the only reason is again to my point is we can't think of these measures in isolation and we cannot think of immunization and isolation. A patient just does not come in for influenza and for vaccine. So we have to keep in mind the reality of the situation of patients coming in for you. In fact, a lot of things we have to take care of. Immunization, it's just one of whom so we cannot overload.

Again, the reality, the current system which is not going to change in the next five years (inaudible) we need to keep that in mind. I think it's incredibly important otherwise nothing is going to get a change.

Reva Winkler: OK, just to give us a little bit of a different activity, what we want to do is break into, you want to hand out the group things? In the four groups and three of them will meet here and one of them is going to meet in the room around there so Jeff and Caroline and be part of the group.

So the first group I think coalesced around Wendy over there. That group I believe as I remember writing it, so it's on harmonization and alignment. I've got these assignments (inaudible) to the people to go with the results.

Group 2 on disparities and populations, can be with Juliet down on this side. Group 3 is a non-traditional provider and you're going to go with Taylor to the other room to Caroline with Jeff. And group 4 can be over here with me.

And this was – the questions under there were just my very quick thinking just to kind of (inaudible) by no means are they meant to be everything or, you know, ignore them if you wish.

When it comes to making recommendations, I mean you're not obligated to make any. However, there's been enough discussion around the topics that it seems likely you would like to.

So these small little groups are going to help break up the work and start forming these recommendations.

It's 10:00, as part of your group but informal, you know, think of yourself as having a break as well. And so perhaps we can regroup at 11:00 as a whole and we'll, you know, talk about the recommendations that come from the various groups.

For each group, find someone to be your spokesperson to report out and whoever your interest that person is, we'll help kind of put your recommendations on the slide so that we can show them when we talk about them.

(Off-mike)

Female: Well, I divided you up so that so that there were equal.

(Off-mike)

Female: Sure, that's fine. If you feel like you're again, I just want to …

(Off-mike)

Female: OK, sure, sure, if you feel, yes, completely misplaced, find your place. Disparities over there, image is over here, harmonization over there and Taylor is going to take the non-traditional provider group to another room.

(Off-mike)

Female: I know.

(Off-mike)

Female: Two is going to be over there with Juliet that's the disparities. Non-traditional providers, Taylor is going to take to another room since we're going to call Jeff and let him join that one too.

(Off-mike)

Female: We're just waiting to, as we get the last set of slides up to for the report on (inaudible).

OK, it looks like we've got notes for me to the four groups. Thank you all for your thoughtfulness in addressing these topics and let's go and now see where we're at.

Juliet can you bring up the first group? I mean I'm just looking I got blank screen.

(Off-mike)

Female: We got a technological issue.

Got it. (Inaudible) everybody.

OK. All righty. So we're going to start with the first group which is around harmonization. We got that one, no, go down. OK, we got them backwards, so that's OK. All right.

Cool. Who are from group 1 will start to tell you a story.

Male: OK.

Reva Winkler: Question. When you're talking about the harmonization and new measure states on the standard data element, do you see, you know, continuing with this harmonization around the construct that NQF has done previously that a lot of the CMS measures are already harmonized around, that we talked about some of the numerator categories to be able to separate the data, or was there something else?

Male: So Wendy told us that there's been some intent to do some harmonization but that it's not that many have been …

Female: Right. Yes, I was just commenting on – we've had guidance around harmonization for a while at NQF but I think on the whole, we haven't really had, n Reva this is a question for you (inaudible) more being on the performance measure side, actually had a lot of measures that had been harmonized …

(Crosstalk)

Reva Winkler: Actually this happened in one of the areas. And this was the project that Roger did with us back in 2008. And so most of the CMS facility level measures are harmonized around that measure construct and that's the one where the numerator elements of, you know, vaccine received, vaccine refused, vaccine contraindicated are the data is maintained so that you can break down those categories and the overall measure is the sum of those.

So that was the construct and when this group had their webinar at the end of January, Roger asked, you know, what happened to the recommendations from that group.

And I distributed to you all the list of the measures that are harmonized along that and it's pretty much all of the CMS facility level measures as well as the CDC healthcare personnel flu measure are all harmonized in that way.

So the question is, is that the specs you're referring to. That's all, I'm just trying to be sure I understand.

(Off-mike)

Female: OK.

Male: Because I mean I think this fact will eventually going to depend on, if that was done in 2008 and was OK at that point in time, that's OK. But did all these things are going to go over the hard and fast rules. The point is harmonization is important based on what would work best at that time.

Female: OK.

(Off-mike)

Male: (Inaudible) number one because that's a very high level recommendation and we did talk about some of the details of what that means.

Female: Yes, yes.

Male: But we felt, you know, that's an implementation issue …

Female: Right, now. You're right.

Male: … leave it to you to also think about the data. Because now there'll be issues like you know, what if not all the existing (inaudible) do not – are not be – they don't expire at the same time. They're not (differently) at the same time, what do you do at those guys? Suddenly, how do you manage but we felt that wasn't, you know, the competence of NQF that we were – they want to micro manage that.

Male: Or the people who were in the group just to let them know we spend some time on definitions and harmonization doesn't mean that they sound good together. It means that they have the same data elements and it has something to do with the data behind them in a particular way. Where is this, where do we use consolidation, just had to do with a fewer numbers of measures.

There was also a lot of things that we learned about the cycle of these measures that they have a three year life cycle. What Reva says that's maybe that's a thousand years …

Reva Winkler: No.

Male: But it's somewhere around there. But they, but at some point, they come up for this – we thought of them as dying, they needed to be resuscitated at the end of three years. But no, they just, somebody just has to come along and say keep it up boys, you're doing a job or girls or whatever, you're doing a good job. That's called maintenance and that means they have to submit a form for it and so we wanted to be sure that in our little thing here and because I don't understand the terms that are well on the way you all use them, what I wanted to be sure was that this (meant) that when they do come up for recycling or recycling and then we should harmonize and consolidate at that time.

Male: These definitions are incredibly important and I think it's – it will be helpful if David can just explain the harmonization consolidation. Because consolidation is a – I was a little bit uncomfortable with it and David did explain it really well, so do you want to just …

David Nace: Sure, as I remember. What would harmonization and consolidation, I though was harmonization was kind of looking at the way in the data is collected so that, you know, if we look at influenza vaccines, some groups would say, you know, conducted between, you know, the people between the months of October and February 28 and some would say November to April.

We want to make sure that the measure is conducted similarly across and that's harmonization. So you could take two measures and you could make one measure out of it by just making sure they're measuring the same time frame in the same way.

Whereas consolidation was another way of reducing the overlap of measures and the number of measures overall by saying OK, we have a measure that says we should be measuring adult populations 65 plus for flu and we have another one that says 50 plus for flu and we could just consolidate those into one where, you know, the end result is a reduction in the number of measures, so …

Female: So, can I just ask a question? So at the end of day, is it your purpose to measure vaccine usage in the adult population so that you can increase it? At the end, it's like have some portfolio of adult-recommended vaccines that prevents X (inaudible) in the adult population and you're trying to come up with what that portfolio is and how to measure it and you don't need 500 measure, pneumococcal measures to get that information and if you consolidate your – the existing measures, it makes room for the gap measures that we just put on the table, is that look at the end of the day, what we're trying to do is it …

Male: Yes. I think essentially we would say that there are – there are a group of vaccine measures out there that are measures of good practice but we should be recommending and we don't need 472 to address just – influenza is important, don't get me wrong, but not that many for itself.

Female: My question for you Reva is that when we are done doing what we've done for two days, we sort of said we sort of have, I don't know, ten measures that were gaps that don't even exist right now and that's what we want to go off and figure out how to fix. But we had all those other stuff that's just hanging out there who puts that whole thing together so that you come up with the portfolio or whenever you want to call that word but you know what I mean.

It's a many-pronged effort. I think we're hearing from the federal side that they have an interest in filling gaps but also reducing, so a good really part of that portfolio are federal measures, I think of the 220, 108 of them were – came from – from the federal side of – and so we've already seen interest in making that part of it more simple.

When it comes to NQF-endorsed measures because we don't endorse all 255, we've only endorsed, yes, whatever it is 15 or something again, we can use those principles in terms of what measures remain in our portfolio and our endorsement, you look at harmonization we always have, it continues to be on ongoing struggle as developers having different philosophies about whether they should or shouldn't harmonize but again, I think that reinforces that harmonization and this topic area is just critical.

You know, it might be just a slightly bigger hammer that we can use. And so, you know, a couple of different arms, the message going out saying, "Folks, you know, we got to fix it." And it becomes a drum beat if you will. Well we got rid of all 255 and put it down to a portfolio of like 20, probably not but as of taking the ground to establish that that's what's needed and those who have an public utility to do something, you know, can act.

But I think, you know, working NQF's role, federal side's role will make some significant impact. Any thoughts from anybody on this?

Female: I have just one thought, as I really like aggressive consolidation, that's my favorite part. Just on the item four, one thing to think about when we're looking at population versus provider measures is that a measure is specified a way NQF is described can be used for both, we discussed when you have that split numerator of the same measure depending on which elements you combine and report can either be a process measure of vaccination or a process measure of assessments.

Female: These are all acceptable, everybody, you know, behind them, good.

Male: I have a question for you. So people come to you and they ask for endorsement of their measures, right? And so then, when they do, you can say to them, well this measure is not in harmony with blah, blah, blah and so and it's just adding on and we're in the process of consolidating so as long as your measure fits with our overwhelming philosophy, consolidation and harmonization will be happy to endorse that.

Reva Winkler: Yes. To a certain degree, harmonization is one of our evaluation criteria and we ask our steering committees to evaluate these measures for us to apply that criteria. You know, there are times when there is good justification for it to not be harmonized in some of other topic areas and that is a discussion point as part of the evaluation process but I think this source of recommendations can add sort of fuel to the – to when we look at immunization measures because it's such an area that's so chaotic.

Male: Amir corrected this in his reading of it, the recommendation 5 to the (inaudible) including importance of populations, it's not for importance of (inaudible) yes.

Female: All right. And the spokesperson for this (inaudible), and that was myself, Dr. Hunter, Dr. Riley, Patricia. You know, you talked about a bunch (inaudible) and well first of all, we felt like immunization disparities, it's a pretty good indicator for the bigger picture of health disparities. Is there a (inaudible) of healthcare? And you talked about, you know, what is really the need to measure this because it's a very burdensome, it can be burdensome but, you know, it's really important to identify these disparities and then address them.

We talked about some of the national data sources that are out there especially BRFSS and how does, a lot of limitations around BRFSS data and including small sample sizes for underserved populations, so we'd really need better data from the national sources. We talked about, you know, the burden of measurement and it's really kind of centered around the provider's role and that this is probably too burdensome for providers to coalesce and assess and kind of felt like national data sources, the two sources his possibly other resources like (inaudible) registry PRAMS and that sort of thing might be good data sources for immunization disparities.

We talked about special populations could possibly be easier to measure. There are, you know, like I've kind of mentioned cancer registries in the PRAMS survey for pregnant women and then also ways to identify diabetic patients and patients with chronic conditions through the EHR. And we also talked about maybe there is an opportunity at the national level to modify an augment that data we get from BRFSS make them more reliable data source and we overwhelmingly recognize the challenge that with disparity, it could be identified at the national level but it has local implications in the way you address the disparity that's so much different in some space to stay and in some community to community.

Thoughts from anybody.

Male: What's BRFSS?

(Crosstalk)

Female: No, I'm sorry. I didn't – that's OK. It's run through CDC but it's really kind of done by the states so they're sort of a core set of questions that includes adult immunization that every state does and then there are separate modules that states can add on if they want, but it's nice because unlike (inaudible) it provides the state double data.

Male: It's a random – random telephone (dial) sort of …

Female: (Inaudible) non-institutionally.

Female: What is the – would the specific recommendation for BRFSS be done because I actually don't know anymore about it and they just said, it's to have a bigger sample size so you can look at one-way populations or being able to look at other types of disparity like better income data or what specific change?

Female: We talked about this sample size mostly, and we kind of compared, I know PRAMS is a completely different animal than BRFSS. But you know, how they – oversample underserved populations and how you can really drill down and understand the data more.

What's perfect data is (inaudible) really speak to Minnesota data but you know, some of our minority populations, there's 500 or less people in that sample and it doesn't really, at least when I see the immunization rate and compare it to the Caucasian rate, I feel like it just doesn't quite tell us the story of the disparity.

Male: When we've actually compared BRFSS data to some of our state immunization registry data for childhood immunizations, we've seen disparities and that's right for the particularly big among some of the subgroups. And the concern has been that the sample size BRFSS is so small for a small state population wise. But in – you dilute that even further when we go into subgroups.

Female: The reason that we were trying to bring up that forth is we hope that adding ethnicity, race ethnicity to these measures would be particularly you have to

call it burdensome such that you might want it to be that but when you recognize the power of having the data, is you have the data if you knew that there was a, you know, ethnic disparity between say flu and you could further drill down and say OK, if it's 80 percent of the Caucasian it's 50 percent of the African American then you could drill down and say, why is it only 50 percent of African American, is this a message, is it the access to how disparity at the, this belief, you know, whatever it is and then you could utilize your unlimited resources to address what those things are, if we all recognize the power of having the information but it just seems in our small groups of providers, it seems very difficult to be able to get that information and utilize, you know, putting race ethnicity in the mix of an already difficult measure.

That's not, that wasn't – none of us actually were big measurement people in the group so it's maybe hard to really say whether or not that's real so maybe the measure – how easy is it to get this ethnicity, maybe it is (inaudible).

Female: No, I appreciate the (top deal) because it's obviously critical to measure and it does seem like something that might be better measured through the, like national surveys and I like to focus on BRFSSS because in his, you know, it show terrible disparities that you can't really break it down by the states, so it's like OK.

Nationally, we have a problem. Now what? I just said, so BRFSS doesn't over-sample at all.

Female: It's a random. Go ahead.

Male: There are different populations that are – geographic populations that are oversampled in BRFSS so in particularly in large metropolitan areas there's over sampling that's done.

(Off-mike)

Male: Not that I'm aware of, not the race and ethnicity.

Female: I don't even know that, that's kind of (inaudible).

Female: It looked like, if you just look at the BRFSS data on flu, the numbers are when you start looking at the – not tiny but the numbers are fairly small when you start looking at the business (inaudible) African-American (inaudible). And so, if this thing helped you, I wonder if that's really accurate. You don't know?

Male: Maybe I can just give an example to that. So the composite measure that we put together which we discussed earlier which is this mix of adult vaccinations and other preventive services particularly the cancer screening, we – it is possible for example to do that composite measure which we've done it for both 50 to 64 year olds and 65 year olds and older by state and we published, we published that data.

We did do a study which we published last year looking at disparities in a composite measure but we were really only able to do it and with the disparity by race and ethnicity where we're really only able to do it at the national level, we couldn't do it at the state level for reasons that you have already identified.

I would say just I, you know, what we did find which is very – to me, very interesting in doing that study is that if you look for example at this was for a 65 year old and over both men and women at the disparities which were significant in the composite measure.

We then did sub analysis to look at which component of the composite measure immunizations, cancer screening, where we're responsible for the disparity. Was there one that was particularly responsible for the disparity and before we do the analysis, I thought it was going to be colorectal cancer screening because it's the most expensive intervention to do, turns out that the responsible component for the disparity between African Americans and non African Americans is actually adult immunization, flu and pneumococcal vaccination.

Now we did some modeling, we said if we could get what would happen to the disparity in a composite measure for 65 year olds and over if we could get the flu pneumococcal immunization rates in the African American community, the same as the national rate? Well that happens when you do

that is actually disparity flips and African American women for example are more up to date than non African American women if you can bring flu and pneumonia up to the national level.

We probably should send the American Journal Preventive Medicine.

Female: I ask you so like what's your thought on that? I know that's not the topic but like why, because it is an access, right? They had access to get colorectal screening, presumably could have gotten a flu shot if you were offered the flu shot, right? So you don't know whether it was – they had the accesses and they weren't offered or recommended, or …

Male: All right. So we – I would say we know, you know, the flu shots are available at every pharmacy and if not, I mean they're expensive but they're not. It's usually expensive so we do not do in the study, look at, is it that there's just simply just demand for it or is that that there is, you know, that they're not – it's not being offered and so we don't know the answer to that question, we just know and this is why I think the actionable piece is really interesting.

We do know that if the goal is to eliminate the disparity in the composite measure, then, you know, we know what we need to focus on. It's not mammograms, it's not colorectal cancer and, you know, clearly all of those things we'd like to see higher, the way we're looking at reducing the disparity by increasing the lower end of the disparity. It's going to be to adult immunization.

(Off-mike)

Female: Do you think that we should change that and say that racial ethnicity should be part of a measure because it's doable as a opposed to rely on.

(Off-mike)

Jeffrey Duchin: This is Jeff, I'm not sure if I'm – in this part of the discussion but many immunization registries had (CL2 raised) ethnicity and although it may not be completely populated and may vary from jurisdiction to jurisdiction, I think that making that a measure will drive the collection of that data which I think

it's part of our purpose here. So I think it would be useful to include that as part of the measurement.

Female: We have – to speak to (Nick) and we talked about this a little bit, we have really good data on children because we can put them right from the birth certificate and straight into the registry. For adults, it's not a required data field and we don't get – we don't often get that filled in, even if it's available on the EMR it doesn't necessarily mean that's going to end up in our registry

(Off-mike)

Male: I think as a preamble to this section, I think it'd be really nice if we could mention some of this discussion that I think what I'm hearing is that it's a huge challenge in adult immunization for disparity takes this, I mean I personally as an Asian-American, had no idea that there was a disparity in the pneumococcal vaccination for Asian-Americans until I had to write a paper, which is kind of sad. I think it's an awareness issue but I think by measuring, it allows us to drive attention but I am very concerned about the ability of providers which is I think where this is actually happening to actually do that measurement, I think it's a big burden.

Female: From a measurement perspective, disparities are something we deal within all measures potentially and what I hear from your conversation is some of the typical concerns about that kind of data but this was a relatively unique sort of approach that I think it's interesting to explore further because what I heard from you was that at the provider level, that data may not be very good, it maybe difficult to collect, it may add burden but the information is important so that perhaps at the population level where we're looking at bigger pictures when these numbers are going to be bigger.

So again, some of the caveats around the survey numbers, but that might be the more appropriate place to focus in on stratifying some of these results by race ethnicity, you know, whatever group are appropriate to provide that big picture context, the numbers are big enough although even in sometimes with the survey samples, they can get small but they're at least is big enough to be able to do it reasonably and it's something that is already ongoing and has

already done the definitions exist and I'm assuming they ask the questions from a survey such that, you know, you get the data that you get.

In a fairly standardized manner which is probably isn't the case at the provider level. So that's what I heard from you is that's important but perhaps we'll get our biggest impact by measuring at the population level for that context within year to drive what's going in your local area rather that trying to measure the provider level and stratify it where you might run into methodological problems, definitional problems and small numbers problem.

Male: Yes. Just a caveat, I support that, but just a caveat, it's not actionable, you know, with the national, we talk about this all the time and nothing ever happens. It's – just put it up that (inaudible).

Female: Yes. I mean, I would ask (Jim) particularly, health plans usually are our biggest provider group that we have numbers that can be use in this way. What are your thoughts at a health plan level?

(Off-mike)

Female: You need your microphone.

Female: Medicare or Medicaid, we got the information, it comes through and we have about n 95 percent completion which is pretty good a person can opt out. In our commercial population, we've tried everything. We've worked with employer groups, we've tried all sorts of things, so we have now resorted to incentivizing providers to ask a question. We want it self reported from their patients and submit it to us and we'll incentivize them for the submission process. So we have a process, new process measurement for it.

So we'll see, we're at like 10 percent right now in our commercial population so our goal is to be at 20 percent by September and that would give us enough volume of data and to actually do some good analysis.

Female: Are you using the information, the commercial population aligned with what you get from Medicare and Medicaid.

Female: Yes.

Female: So that, you know, if you're using the same date of definition.

Female: We actually – no, we actually have an expanded with race and ethnicities beyond what CMS defines. Michigan has a high population of Arabics and Chaldeans without that's even different. So we have added some additional foot so we can align but we have some additional granularity so that we can get down to those subpopulations that are really important in our state, you know, and your might be Hispanic and your state might be Vietnamese, our state is the Arabic subpopulation. So we have to be able to look at this.

Female: All right.

Male: I just wanted to put it. I think that there are some health plans that have been able to successfully cross this confirmation and they at least they're some kind of bonus point I guess for that effort so the (inaudible) you know, we're able to kind of get their data rates off and they had to go and send every – you know, all the people that they wanted to get information on the survey, asking them about it. That was the only way that they could get it but I do think that it's feasible, if with difficulty and then when you have the information, it's potentially valuable, both probably from a quality improvement perspective and the for (NSC) as a marketing angle as well.

Female: The only other thing is it that we didn't slump race ethnicity with special populations so the special populations piece let’s be clear about this like we felt like diabetics, I mean you can get that on the provider level. I just want to make sure (inaudible).

(Off-mike)

Male: Out of this group and what are the specific recommendations in a lot bullet points that were there were – that or I think we need to narrow it down. What are their key recommendations that's going to help you later on, all right?

Female: That was my next question.

Male: Here we go. Group can identify what are the recommendations you guys are making because some of our factual statements were state recommendations.

Female: Right, group members correct on anything here but I think the recommendation is really to get more robust data from national surveys and really try to understand the disparity and then where databases for our special populations already exist. Examine those and like we said, we feel like that's also something that can feasibly be collected at the provider level and something we did, you know, we did mention that health plans often have this data but then also where the caveat that underserved populations are not as likely to be covered with health insurance and especially with Medicaid expansion, we even know that they're not always eligible for Medicaid now even under
ACA.

So, you know, kudos for having that data for health plans but at the same time there are some certain limitations with that too. So I guess the strong recommendation is to get more robust data from national surveys especially BRFSS.

Female: Given the conversation that we've just had though would you all agree with putting in some kind of recommendation for, to encourage that kind of data collection in health plans. Because I think, you know, there are some studies that's even among the ensured, there are racial and ethnic disparities, there maybe differences in the types of providers, the different adult piece so it is, you know, like LJ said, it's not actionable at a big level and at a provider level, if you can say, gosh, here's the real problem here, that you need to examine in your practice, how you do things or in your plan, how you do things that something that people could ac ton. Even if it's not, you know, 100 percent feasible and I do agree with the national survey, it's the primary way though.

Female: Yes. I think we will agree that wherever can we cut to health plans, it's a good way to go because the right actionability is there.

(Crosstalk)

Male: Go ahead Jeff.

Jeffrey Duchin: OK, thanks briefly, I just – I definitely support that statement and really transcend this immunization relevant across a whole range of different health conditions.

Male: I just think, you know, when you craft the words for this recommendation, you have to be very careful because there's no denying that we have a disparity issue in adult immunization and if we craft to recommend it's the same thing that we just need to collect more data. It makes us look really – it just makes us seem insensitive, so just draft that accurate. It just – yes.

Male: Craft it then.

Female: I'm looking for the part that is less, you know, something that's a little more robust, what is that your recommendations? What do you want to say LJ?

Litjen Tan: LJ and I'm …

Female: Help me.

Litjen Tan: So it just seemed like we're, there had been a couple of things that we've said, well we're not really ready to measure it in the sense of measuring people and challenging them to make changes but we're at the stage of trying to understand it more and doing research on it. It seems in this case that we need to understand the disparities more rather than try to measure them at – but, you know, measuring as a part of understanding but it's in a kind of a different phase, isn't it, than measuring and telling people to change.

Male: I would say something along the lines of, you know, there's robust national BRFSS data to indicate disparities in adult immunizations. However, at the state level and at populations level and something like that, the data samples are still inadequate to move on a specific process measure to, you know, at the provider to define a provider-specific provider level of measurement. That would be the ultimate goal and I think it's kind like a point on the hill but it's something that – at least that this is where we want to get so I believe strongly, we need to measure this at the per patient level, at the provider level but I just don't think that we're at that point yet.

Male: I guess what I would add (inaudible).

Male: Doctor, he's done it so I mean.

Female: I don't understand – so you did it, right? You've already done that.

Male: We measured the (inaudible) measure at the national level and we also measured – at the national when we measured it, we had a sufficient sample size to look at different racial and ethnic groups that'll have to say Alaska Native Americans were even there at the national level, the numbers were too small to come to any conclusions. The confidence intervals were just too high. But I would – what I would just going to add to LJ's comment it that, you know, to me, the actionable part is a local part and, you know, if there's, you know, it's not national or state programs or campaigns that are going to make the difference, it's what people do on the ground and I think that the point about the data is that we do – we cannot drill down finally enough to know whether those actions are making a difference or not.

We can get a baseline, do something, do a bunch of things and measure it again. We can't do that even at the county level. So, you know, to me that's, you know, that's the piece that needs to improve larger sample size, more over sampling even if it's just in, you know, particular communities where you can then try a different set of pilot programs but to me that's the link between the data and the action and I would also say I, you know, Roger I – we have I mean a gazillion studies to document disparities in a variety of whether it's socio-economic or racial and ethnicity.

I don't think what we need are more studies – what we need are ways to measure whether what we do makes a difference. That's what I'm talking about.

Male: Recommendation we need to make I think.

Male: But caveat it with that first statement, the thing that, you know, there is (inaudible) national data of disparities in adult immunization, however what is

lacking is data that is not even (inaudible), it's local data that actions towards reducing disparities are impactful.

Male: Yes.

Male: Impactful is a really bad word. So think of another word.

Female: But I think that this is probably a question for the state folks because I don't know how BRFSS is done but it's the sampling customizer would've been a recommendation because I think (Jim) made a point, you know, in Michigan maybe the Arab-American population is really big. Nationally you can't really look at American Indian Alaska Natives but in Alaska, or Oklahoma, you might want to look specifically there and in Minnesota, you might not just say – I don't know maybe in the Hispanic population smaller or less important but the smaller population is hugely important I mean is that how sampling is done, is it possible to make changes like that?

Female: I've worked some with the BRFSS purpose in our state and I believe it is possible to over sample but again the issue is always the resources to make those additional telephone calls through the process that's setup. The over sampling is not always an issue.

Female: Because I think the point is well taken that we don't need more studies to say that there are disparities but at the same time they're also not uniform and you don't want to say, well in every state, we're just going to assume every adult that doesn't have white skin. It's doing worst in all these I've seen in all these age groups so you do need some sort of more customized data even if you can't get down to the provider level.

Male: Well, we also need to look at other sources of data because – so for instance in our population, we have a pretty high capture for racial ethnicity but those who don't, we use to run the algorithm which is based on geographic location in all actual geo-coding and last name and then they impute racial ethnicity for (inaudible). It's pretty well validated. There's other way to doing it. That's all.

Male: I think that I like the word customize.

Male: I'm sorry go ahead.

Male: I thought what made it with the word customized data is I like that word. This what we're trying to get …

Male: I'm wanting to going to motivate the group to do something more beyond just measurement in data development, I think there is a suggestion that policies, in kind of some of the facts and so in the department we always harp on the fact that, you know, there are white racial and ethnic disparities in adult immunizations and the childhood immunization disparities that were existent, (inaudible). And so there is a notion that policies can't have an effect.

Male: Big policies of (inaudible). Vaccine to our children, I mean that's why we have no disparities in the pediatric population, I mean no (inaudible). The other thing is also is I remind people that disparities as much as racial ethnic, it's also was economic and also geographic. I mean I will argue that you can be white skin and if you're living in the rural population, you will be un-immunized.

Male: Ernie, you're saying that we should be making some more of (inaudible) and disseminating it to what we are just saying?

Male: I'm hoping that we at least like maybe the interest section talk about some hope that, you know, that it is possible to reduce disparities and that, you know, and immunizations are example (inaudible) less effective and it's not that you (inaudible).

Female: So there are some cities also looking at the standardized offerings, I think there's concerns about to be focused on measurement then may there's a way to – and I'm just saying it's about actually thinking about if you could operationalize it, but if, you have an accountability measure for standardized offering of vaccines in the provider office or health plan or whatever and you have the race ethnicity data. That actually would allow you to track your, you know, you're assessing, you're making the same offer to all your adult, whether they're all accepted equally or maybe not, that data indicates that that would help a lot in reducing disparity.

Laura Riley: Yes but I think there's also lots of data that suggests that there is difference in messaging. So what resonates with you does not resonate with me and that's going to show up with this disparity in my (inaudible).

Male: So what I would say Laura is I can cut to the chase here, we can go and give you recommendation but it's not going to be accepted by the group and that is I think we measure it at a provider level as a process and that will change behavior and hopefully and in the process with advocates in the ground we'll be talking to providers about how to make that messaging. How to do that communication to get to – to facilitate the measurement but I just don't think that's going to fly in this group like (inaudible) I mean I think there's – there's going to be a discussion about lack of data to support that kind of strength down to their provider level. It's just going to be a talk of lack of data sources which we've already talked about. So.

Female: That is a huge or and I would also strongly wonder about the integrity of the data. That I think if you put that huge burden down there – like I will get some of the things that are checked of when you look at race ethnicity for just our patients and I look in electronic medical record and I look at the patient and like – who thought that woman was, whatever they'd label her at.

It's like clearly cheated and say she was that. Someone is a nurse who looks at her or the, you know, the ladies and science people in the registrar decided that they – so I – I worry that you end up with bad data. If it's really burdensome you end up with stuff that you are actually are erroneous.

Male: Do you think people would (inaudible).

Female: It (inaudible).

Female: One thing just a – (Jim) mentioned that they get data from Medicare and Medicaid. So that's a significant population, it's not everybody but it's some. And so perhaps, you know, using those as starting point to better understand disparities in those groups that – for the, which the data exist.

Male: (Inaudible) recommendation about health plan. Encouraging health plans to capture that data and at least that the starting point. I was, you know, I, you know, I wish there was policy where (they'd) just kind drive this better. Because I think this is something that we kind of failed off. But I just don't – I mean I predicted the push back (inaudible) exactly what (inaudible). And I think it's – but it's, you know.

Male: I think it's more complicated than Laura says. I think race is a moving target, people are mixing and moving and we are evolving country, you know, and one year we're talking about race, once way and the next couple of years we're not even using the same words or (inaudible).

Female: So I have two daughters, OK and my husband's white, I have two daughters. My older when she'd asked the question for some black man, my younger daughter will refuse to present anything that there's no choice for half and half. So in the (SAT) she insisted that is not marking of the box and she applied to collage would not mark of the box. And my older one put down the African-American. It's a thing, kids – I mean this is a generation of lots of mixture and those kids are doing their own thing. How that's going to get counted will be very, very interesting.

And that's not even, that's them self identifying, right? That's not the nurse deciding what she things they are.

Female: Well and to Laura's point when we have this recommendation we should definitely say patient reported for assessment today when we're recommending (inaudible).

Female: Yes, and I think something that I've struggle with right of the bat, we kept having this issue thrown out there. It was just that, you know, the appropriate, the social determinants of health and health disparity isn't just thinking about how tiny a proportion of that is actually actionable in the healthcare provider's office. And, you know, like Eddy said this is an issue that comes up over and over again, year after year and it hasn't changed and so I just, you know, I think about all, you know, we can't – how could we impact system change around measurement.

Is it feasible, is – I mean that (inaudible) really good indicator of access of healthcare over a – all of those bigger issues. And I know that's moving further away from coming up of a specific recommendation that it's, you know, something that I definitely have in the back of my mind.

Male: Maybe it's just a (framing) issue, I mean I think, you know, we have like little introductory blurb on top of these things and maybe something even (inaudible) which is that in affective way for improving adult immunization (inaudible).

Male: Well, I'll forward to you (inaudible) when I was a (DMA) in my group there was commission called the commission and healthcare disparity. And they actually published a couple of papers in (Jammer) on what it means to collect data. And I think it – It (inaudible) some recommendations there because it's broader than just immigration.

Female: Well you're right and in fact NQF has done a fair amount of work in this usually (inaudible) through (RWGF) actually that's one of their big focus areas. And so we do have recommendations that do exist and I'd be happy to pull those in. And, you know, because again you're right, this is not an immunization alone problem and (never) something we want to try and address in all the appropriate measurement arenas. And so we just don't want to overwork it here where we know there are existing disparities. So if that, I can certainly pull in some of that information.

(Off-mike)

Female: Yes, yes they, I mean they've been through this stuff a lot. So we're at noon and I was looking (inaudible) are we supposed to do a public channel?

(Off-mike)

Female: Oh very good, yes. So perhaps – oh we (haven't had handed) listing that – let's just see. Operator is anybody in the like that might want to make a public comment?

Female: At this time if you would like to make a comment please press star then the number of your telephone keypad.

And there are no comments at this time.

Female: Yes, that's a – OK, thank you very much. Jeff we're going to take a 30 minute break for lunch right now.

Jeffery Duchin: OK thanks I'll call back then.

Female: Thanks.

(Off-mike)

Male: I can start. So hello? OK, I think the quicker we get going and we can – so hopefully we will be able to wrap it up soon and we can the night, weather outside. So thank you so much again for Reva and Juliet for wonderful lunch. It was very, very good, we all I'm sure enjoyed it a lot. I wanted to back to the disparities issues and there's something that Ernie started out and I haven't been able to (get that). Sorry guys. I think we have to …

(Off-mike)

Male: … yes. I think we should make a – start thinking a little bit – make a recommendation that's slightly different that what's been happening. I think Ernie does have a point. We don't want to make a standard recommendation that every group tends to make in this country. And there are something that I heard from (Jean) I mean theirs is definitely – the data is out there. So for us, I don't see why shouldn't be making the recommendation along the lines.

Although maybe we should be measuring it in the health plan level and (inaudible) date is there. And I just wanted to kick it off the (bad) in the – as a launching pad. (Andy) do you want to add anything because you and I just discussed this a little bit as well. It sounds – (Andy) do you have? None? OK.

(Off-mike)

Male: Exactly it doesn't – so standard recommendation. I think we have – from this group it will be better to have something different than just – (Jean) do you – want to add anything. Or do you …

(Jean): No I think that these are good recommendations that we start from (where) – measure of the health plan level. The populations to present the data for.

Male: OK so feedback from the group before we make it a recommendation.

Jeffery Duchin: This is Jeff, I agree with that.

Male: Jeff and you are missing our good lunches there.

Jeffery Duchin: Yes, it sounds like I'm also missing good weather, I'm very sorry I can't be with you.

Male: We're all sitting outside in the park right now Jeff.

Jeffery Duchin: So am I.

Male: The one thing I would say is – so (Jean) does all health plans, also collect the CMS and data – and Medicaid data and compile it.

(Off-mike)

Male: OK. (I don't know if anyone) to make a specific mention of that.

Female: I should probably say, I'm not secret service Medicare, I'm talking about Medicare advantage. And Medicaid, I'm pretty sure that's standardized across all states, so yes. Do we just want to be sit the specific in terms of – I know that we can also be talking about economic disparity but I think for race and ethnicity we want self report. Do just want to say that in that.

(Off-mike)

Female: Where I, you know, I was going to pull in some of the general disparities …

Female: OK.

Female: … the (inaudible) represents and that I know it's part of it.

Female: OK perfect.

Female: So that you're absolutely right. That's quite standard.

Female: OK.

Male: Reva what would be the recommendation, do you mind if …

Reva Winkler: Well I think, I think you can recommend that the measures be stratified by race and ethnicity at the health plan level. You know, with recommended measures to be developed and that's one of the aspects to those measures so that they should have the capability being stratified at the health plan level, so I – race and ethnicity.

Male: Everyone agree?

Reva Winkler: Are we willing – so Roger talked about using the (rand) algorithm and we in the past have used it as well when we had lower self report. Are we willing to let health plan start out with using an algorithm and then move towards the self-reporting?

(Off-mike)

Female: I would think so.

Female: Yes, I mean it's better than nothing.

Female: Yes, let's start somewhere.

Female: Yes.

Female: That would just be my …

Female: Yes we can mention – we can mention that as avenues of identifying those strata.

Litjen Tan: Between the measurement issues, I just want to say, you know, again it's not just race and ethnicity (inaudible) but I don't we can measure data. I mean I don't know geographic data, zip code data could be used for that by I don't know whether you want to recommend that. I just – I know that there are huge disparities by geographic region as well.

Reva Winkler: LJ, let me just explore what's explicit in some of the NQF workaround disparities and some of those other things and maybe I can pull in some of that stuff. Because you're right it isn't necessary exclusively (inaudible) some of the other ways of looking at sub population. And, you know, I can – I'll just remember to share that with you all. But I think it's the same stuff you're talking about.

Female: But also one of the reasons that we wanted to augment the national surveys is because that does give you some geographic information. That you wouldn't otherwise guess. And they're already collecting it, so we just want them example for.

Male: All right, so that I've been asked to share the discussion points of this group and delighted to do so. The group consisted of, of course, myself and Doug, Carol, sorry, is it Shary, where is she? Yes, OK.

All right, as well as our friends on the phone so we have both Jeff and Eddy join the group as well. So I guess just to level set a little bit about this nontraditional provider spaces. We spend a lot of time discussing the role of pharmacists. And I think appropriately because well, first all, a lot of the folks in the room were pharmacists or are very familiar with pharmacy practice. And I'm glad that we're going to be opening this up to a larger group because I think that there's some expertise in this room for other practitioners that could potentially add to the viewpoint that were expressed within our group.

So there are some important points about why pharmacists in particular would be an important group to discuss. They did over 20 percent of vaccinations in the 2012 and 2013 flu season. They do more than half of the zoster vaccinations and we've – zoster's been prioritized as an important one. But

there's some certain points about measurement when related to pharmacists that I think should be brought to the forefront.

Under, I think I mentioned already that under current legislation such as the Social Security Act pharmacists are not considered to be providers. And there's implication associated with what provider status means. There's currently a bill HR 4190 that's on the House floor and a companion bill that's about to be introduced in the Senate side to incorporate pharmacists as providers and this is being aggressively pushed by the profession.

I don't think that you're going to find a more willing group to step up and take accountability. But pharmacy itself, the profession, has gone through what I would characterize as the five stations of grief with measurement. So it started with denial, no, I'm not being measured. Well, yes you are and they have been for years. And then what follows is anger and then depression then acceptance. And finally, I think we're getting close to empowerment.

Some pharmacies are using this as a way to show that they are competitive. That they shouldn't be narrowed out of networks, that they should be compensated for the ability of them to move critical measures that health plans are being held to in a meaningful direction.

Now that being said, this notion of accountability for pharmacists I think is a very important one and Doug did a great job articulating this notion of a panel of patients and how providers are expected to manage outpatients when they're not standing right in front of them as well and to think about them. This is something that pharmacy is still getting used to. But one of the things that we'd discussed and I think it's really important is that pharmacists should, if we're going to open the door for them to have a shared scope of practice, then there should be shared scope of accountability and that there should be a way for us to hold them to a measurable standard, especially relating to immunization.

So some of the things that we identified, question one, which I'll read to you real quick is the question of, how should nontraditional providers be included in measurement of adult immunization?

I guess we addressed the first one, is should they be included and of course, the answer that we came up with is yes. So I briefly touched on earlier that PQA is going to be launching the adult immunization task force. Some of the members of this group have been invited to participate and will be carrying the recommendations of this group forward for specific solutions that pharmacy can engage on. Not as a duplicative effort but to move forward the recommendations of this committee.

So part of the other things that we talked about is this notion of comprehensive data capture. Figuring out ways that pharmacy can feed their data into meaningful measures and for example, pharmacy – the answer to the question too which was what data system exists for traditional providers. Well, pharmacy has PDE data so claims data related to prescription to be submitted that could be included for meaningful measures around immunization.

The other thing that we talked about is also the requirements that are in place for pharmacists. Currently, every pharmacy practice act that I'm aware of requires that when an immunization takes place that pharmacy needs to be sending that information back to the provider somehow. And usually that occurs by fax which of course is this antiquated 20th century mechanism which you would love to see go away.

But there is electronic bilateral communication between pharmacy and provider that can occur. But for whatever reason those pathways has not been opened up, when I think to this – that is going to be something that we'll discuss on the task forces.

We'll have SureScripts, MD On, Relay Health, Switches there to help talk about what needs to happen to get those information stops opened up. But right now it's difficult for pharmacy to communicate electronically back to the physician. So just making it a native part of the way that pharmacy does business I think will really facilitate the uptake of measurability.

And so the last question that we had was related to whether or not this should feed directly, should all of vaccine providers be required to submit data to IIS.

And we didn't spend too much time talking about that. We just said yes. I think that's very much the case that we should come up with or should be a recommendation that this is as much as possible especially in states where it's required, that this should be also required of nontraditional providers.

In terms of recommendations just kind to of sum up that pharmacists and other providers should be held accountable. We identified some areas of potential measurement such as capture of duplicative vaccinations. I think – I found Bob's story to be particularly poignant. If something is not captured it didn't happen in the vaccination world. We need to figure out better ways of balancing the issues of duplicate vaccinations and appropriate capture.

Something else that I've been thinking about and I'm not sure that we talked about it too much but this notion of accreditation as a driver, so measures that could be specifically designed for accreditors. So pharmacy accreditation has a new thing but just merging those two groups, both the (inaudible) and CPTA. Is it the Center for Pharmacy Practice Accreditation, I can't keep these acronyms straight.

Both have accreditation standard which have been solved and I don't see any reasons that we couldn't have comparable things related to both the appropriate vaccination of healthcare professionals as well as requirements for sort of like in a meaningful use capacity.

For pharmacies to have some sort of mechanism in place, the capability to feed into IIS as perhaps a requirement for accreditation or something to consider anyway as a measure of robustness of a pharmacy's capability.

Is there any other points that I'm missing, Doug? You had a great point about this being that – actually, if you don't mind speaking to the Vote & Vax?

Douglas Shenson: Sure, so just one of the key questions – well, first of all, we're talking about nontraditional providers but I think one of the important points of the discussion that came out was that nontraditional providers often are able to go to nontraditional locations in ways the traditional providers are not. The pharmacies work with our Vote & Vax which is a program that I developed which is about making flu shots and other immunizations available and

pulling places on election day, but they also go to senior centers and health fairs and a variety.

So, that's a rule for nontraditional providers which is different. And so, we might – we include pharmacies but perhaps visiting nurse associations would be another group to include there. And then one of the consequences are for measurement I think which is important which is to get some sense as to whether the folks who are being immunized there are the same folks who are going to traditional providers. In other words, are you just playing musical chairs and wherever somebody lands they get there but it's the same group playing musical chairs or are you actually expanding the number of people who are receiving vaccines and, you know, working with Vote & Vax which where I'm writing at the paper now. It turns out about half of the people that we immunized – 2008, we immunized the whole network, you know, 23,000 people on one day election day in 2008, the presidential election.

So, you know, you really come – half of those people were not regular flu shot recipients. So, I think it would be very helpful to capture that piece of it for nontraditional providers. Are you reaching folks who are not otherwise being reached?

The only other thing I would add to (same excellent) summary is that in addition to the pharmacies, we touch briefly in maybe others around the room no more than we did about some of the challenges in workplaces. So, you know, our particularly preventive services including vaccinations delivered in the workplace, are they being captured, what are the measurement challenges for those folks who I suspect are even less integrated than pharmacies are with, you know, the bulk of the database systems. Those are just some thoughts that came out.

Male: I guess, just one of the things that I'd add is that, you know, that's initial question how the nontraditional providers be included in the measurement of adult immunization. I hate to say it but a lot of the answer to that is I don't know. And I would be really interested to hear from the group on what their thoughts around this as well.

Male: Well, one of the things we came up in our group is to be aware of the fact that there are nontraditional or complementary provider quality performance measures being developed. And that the traditional measures need to be talking across those boarders to each other so that you all are measuring the same – the data collection – this data center relation again across that, the harmonization that we talked about in our group and not just within our traditional measures but should be between traditional measures and the measures being developed by complementary providers. So, like when your PQN, you know, it will be really helpful the measures should be devised for influenza immunizations.

Male: Yes.

Male: We use the same data standardization of (inaudible).

Male: Same …

Male: Yes.

Male: … methodologies of existing measures, of course.

Male: Exactly.

Male: I was just going to say, I think the nontraditional provider group is aligned well with what we discussed in the eMeasures' group in terms of recommending a move toward IIS as the common repository for vaccination information and other types of information declination and the like. And that no matter who the provider is, traditional or not, the goal should be defined someway that they can get their information into the IIS and potentially overtime think about requiring immunization providers. No – again, no matter traditional – nontraditional, your – part of your responsibility is making sure that the information gets into the IIS that you have a single common system to work from with much of this.

Male: Yes, and that captures I think such a critical point and absolutely one of the things that Doug measured inside of this Vote & Vax was the number of patients. He actually had a little survey instrument that was – that captured

whether or not these patients had received one last year. So, with that new addition to – or with the folks who would otherwise not receive a vaccination.

Male: We have two questions. Had you receive a flu shot in a preceding year and we ask the question if you had not receive the flu shot here today, would you gotten one some other time during the flu shot season. And using that data, we've put together a constructive regular versus nonregular flu shot recipients. And as I say, half of them for the whole group were nonregular flu shots.

I would also say in relation to our disparities conversation that among African-American participants of Vote & Vax. I wish there was a large number. Maybe 65, 70 percent were nonregular flu shot recipients.

So, again, where you can match a location that seems to be acceptable and, you know, you can make an impact. So, we were very encouraged by that data.

Male: I hope that's remarkable. And I think I'll – so, along the disparities points, that's sort of a very, very good one. But I think you also mentioned that overall, those close to 50 percent of folks – yes, so, 50 percent where it's met new patients who would otherwise probably not have received that vaccine or not have received it in previous years which is further emphasized with the point that we need to have very robust mechanisms of capturing these patients and feeding them into IIS and other …

Male: And actually for that, you know, because whoever feeds data in has an ID number, if you simply associate the ID number with a category of provider, you could, you know, you could really figure that out without actually having to construct a whole new, you know, question and do all those …

Male: Sure. It's already embedded in the claimed, the MDI of administrator will be in there. And I guess that's another good point that we discuss is that none of these stuff is getting lost necessarily like one of the pharmacy goes out and holds a flu clinic. It still have to enter all of those into the normal adjudication pathway. So, it's all getting captured. But I think it addresses the larger issue – there's a larger issue to address is making sure that data gets set into immunization registries, et cetera.

Male: I had a question about measurement to nontraditional providers. So, is it numerator only or is there some notion of a denominator, like, you know, if it's in practice or health claim to do a comparable claims denominator for pharmacist or other nontraditional providers?

Male: I think you could define one. Right now, the – I'm not aware of any pharmacy based immunization measures that are in place. It's sad to say they're not there. But …

Male: Ernest, do you have a suggestion as to what would be an appropriate denominator particularly to the point that Sam made which is, you know, clinicians – traditional clinicians are statutorily, you know, we are responsible for our patient panel. But if you walk into a pharmacy, that relationship is completely different even if you subdivide it to persons who are getting prescription filled.

I can tell you that, you know, one of our – in Vote & Vax, one of our major collaborators was Walgreens. And Walgreens did their own number crunching. And they used as a denominator all persons who had used the pharmacy part of Walgreens. So, that was (inaudible) we're capturing. Everybody walks into the store but that was their denominator.

Male: And I can tell you how it works in other claims like, for example, in PQA's measures, we use prescription claims data for our proportion of days covered metrics around adherence. We have some exclusion criteria around number of prescriptions. So, if you haven't filled a patient within the measurement period, then you can toss out denominator. But I think you could define some sort of measure based on number of fills at least to offer some sort of vaccination service or actually perform a vaccinating service given that they'd filled some certain number of prescriptions at that pharmacy. Perhaps that's one way to do it.

(Crosstalk)

Male: … question, it's to be accountable with that denominator.

Female: Wouldn't you (X out) like you throw out people who had those – sort of those the young healthy people who may not have seen a doctor wouldn't get counted?

Male: Yes, that's correct. But I don't think there's an easy way to capture, patients who aren't coming in to your pharmacy, right? If they're filling it in your pharmacy, they certainly should be counted, but – I'm sorry, did I misunderstand your question?

Female: Yes – no, no. (inaudible).

Female: I think it's most kind of similar which is, why is – when you say a numbers of scripts for a why, I mean, if I fill a prescription at your pharmacy during flu season once, why would I not be in the denominator? And if your talking about access and encounter with the pharmacist.

Male: Because maybe that is sufficient. I'm not saying it's not. But I was thinking about general responsibility of the panel patients, right? So, if there's – if a – there's a lot a (transferring) activity that occurs inside of pharmacies as well. I'm so sure you've probably ever one of these rooms didn't offer a $25 coupon to move to another pharmacy. And a lot of patients do that, get the $25 and leave. And that's not to say that they shouldn't be vaccinating at that point. Maybe you're 100 percent right, but jus from an attribution perspective, like sometimes it's hard to – I was just talking about for the adherence responsibility, that's why there's like one claim is not sufficient.

Female: I guess I was thinking about more as access than responsibilities, but, yes, I don't think you can say a pharmacist has to be responsible for every person that's ever walked through the door and pick three antibiotics or whatever.

Male: Yes.

Female: But if you just talking measuring in the group that might have access to a program …

Male: I think your right.

Female: That's little more …

Male: Yes, I agree with you. Which changes the way we would want to measure them. We wouldn't want to be saying will you only vaccine if your not responsible, how – what are the measurement mean. That – I think that's what Ernest's question brings up is – so, what would we the measuring in a nontraditional group if they are not responsible to give it but they're just helping out and – but mostly we'd expect the most people who came in would have a doctor somewhere else and that's the one who'd be responsible and you guys just help and take up the slack, I guess.

Male: Now, that's the way it's currently structured, you're right. And, granted, it's probably quite a waste down the road but I do like this idea of having everyone who has that scope of practice to – that it has also the responsibilities associated with it. But a lot of these pharmacies embrace it willingly. For example, Right Aid Pharmacy during a flu season, they have a scripted greeting and it's Rite Aid Pharmacy, can I schedule for your flu shot. So, there's no reason that it couldn't just be one script that is the flag at least to offer or I don't know.

To me, the measurement that would be – the most important would be whose putting the data into the system to say how are you going to do with all of those, how many of them went into the IIS. That would be an important measure and one that I would be able to compliment one pharmacy on versus another, another and it would be a great thing, but I'm not sure the usual measures would …

Male: Yes, it's just going to take them more creative minds and minds.

Male: Can you just summarize your recommendation so we can just go back?

Male: It's like what – no. Wait, wait, what are we just talking about?

Male: Yes, right. So, is this on me? OK. So, the encouragement of accountability and measurement of providers of any sort of scope to put – that sits within your scope of practice it should be measured. Then …

(Off-mike)

Male: Well, we've also discussed measure – like measures that are pretty downstream. This is – would be one that's also into that downstream category. I think that a lot of the recommendations from this will be difficult to make actionable quite frankly, but …

Male: Except that I think in the group, we agreed with the recommendation that Roger just made which is that non-traditional a provider should be sending their data to the centralized databases.

Male: On equivocally.

Male: Yes.

(Crosstalk)

Male: That's it, that's it. And I think to the extent that there are measures for nontraditional providers where there's an opportunity to harmonize them with those same – that same subject matter that others are using but that harmonization should occur.

Male: Right. So, harmonization certainly and then the IIS capture was a big one. Also the accreditation possibility for measures of our capability to feed into IIS of potential measure and then workforce vaccination.

Female: I was going to kind of build off of what Doug said and that – is it necessary – does it necessarily have to be a measure of how many people you vaccinate out of a certain denominator or could it be meeting certain criteria for submitting to the IIS it seems have that – all of those and having trained pharmacists.

Male: And I think that's where we are right now, and I would agree that that's what we should be measuring. Are they're participating these submissions doing it in a way and that the data can be used. I would put in, and just speaking personally, that I think it would be very helpful to be able to identify, you know, measurement, it's not a performance measurement but to identify where

people are receiving their vaccines. So, in other words, where there is – where nontraditional providers are making impact, it would be helpful to be able to measure what kind of an impact that is.

So, where the …

Female: Yes.

Male: … just (inaudible), the denominator, it's a community-wide denominator. You know, what proportion of flu shots in this county are being delivered by pharmacies versus other kinds of partnerships.

Female: Yes. I was – I kind of (inaudible) to like especially thinking about (inaudible). So, I mean, you have a certain county or city and is there, you know, thinking about how many immunization providers are there in that county, how many are community pharmacist, how many are nontraditional providers, how many are physicians, that kind of thing. But it's really hard to, you know, to figure out a way to quantify that. And so, maybe for now, it's just meeting certain criteria for being part of the immunization community, so to speak.

Male: Yes, I think that's the most actionable recommendation that we could put out there. So, yes, I agree.

Female: We're trying to capture all of those various spots. We will see.

Male: I guess that I – before we transition on, we did spend a lot of time just talking about pharmacies and pharmacist. Is there anything else that – I mean, some gross submission we …

Male: The question, Doug, in your study with, the Vote & Vax, were there pharmacists who did the vaccinating?

(Off-mike)

Male: We basically – we welcomed all types of providers. So, in 2012, pharmacists were the largest provider, but we also had visiting nurse agencies, we had city and local health departments who participated, we had some university services, so, for example, schools of pharmacy which was a great way of

training right here in town. Well, nearby University of Maryland, the school of pharmacy was very, very involved. So, we had a range of providers.

Male: If there's no other discussion about that, then the only thing that I left out was thanks to (Taylor) for taking such meticulous, you know, that was really well done. Thank you.

Female: All righty. Our last group. And Bob, no, not harmonization, it was – where did they go, they there go. All right.

Male: All right. I'm pleased to give the report for the eMeasures group which were Dr. (Lesley Sommer) and that (inaudible). We have a fairly robust discussion starting off talking about the pros and cons of eMeasures. Clearly, you can measure it a lot of different site, a lot of different silos and lot of challenges with (inaudible). Our thought was that working from the standpoint of any new measures would be an eMeasure might have the best burden benefit balance. As minimizing the burden on – from collecting that data and also potentially if we start off with eMeasures that might be maybe applicable to current data systems and then have those available to work in IIS in the long term might be the place that we'd be able to get the most robust data that might be applicable both to small local levels as well as get this more from national (inaudible).

Encouraging and incentivizing all immunization providers, well, maybe pharmacies whether they'd be employer based, whether they'd be practice based, to submit that at the IIS so that we have a data set that's actually complete enough to work from, recognizing some of the largest comments yesterday, and that's the security and privacy issues I think are issues that certainly need to be addressed.

And then encouraging further development of all the IIS systems to adopt functional standard that CDC has (inaudible) including bidirectional interface so that in an EMR, you're going to have accurate data within your EMR as a (inaudible) and the provider to use the IIS and to put accurate data in. Make sure that the core data elements will include patient reviews and contraindications and allow ideally patient access (inaudible) so that if (LJ)

happens to move from one state to one capital across the country, we have to – where do we get significant data and transfers that with it. (inaudible) sorry.

So, those were the main conclusions from our group.

Female: I just – can I make a comment and I'm a little perplexed by bullet number two, encouraging and incentivizing people to submit the IIS because I don't think it's strong enough. And I think that the experience is probably half of the state have regulatory actions on (inaudible), probably less better than they've done, and I guess it's around half, regulate that it's mandatory to submit. And I don't see …

Male: So, use the word force instead of encouraging and incentivizing?

Female: That's funny. That's the word I usually use.

(Crosstalk)

Male: … that applies much more to the pediatric vaccine as to adults. You know, right now, there are, as we discussed earlier in the meeting, there are a number of places where there are more barriers to putting adult data into the registry than there are …

Female: But there are plenty of places that regulate that adult immunizations must be submitted too. And it sure makes a lot of those problems go away than (inaudible). So, I would argue that that's probably doesn't go …

Male: You want a bigger stick, you know, bigger stick rather than a bigger (caret)?

Female: Sure. Sure.

Male: I have a question for people who work with registries. So, a lot of times, people come in with their children or themselves and they report that they have taken a vaccine. And we talked about how we don't trust anybody to know that. And – but on the other hand, I mean, it's – what we have and I would – like if a kid is up to date and, you know, even though you'd make up the date or whatever, it would be better to say that they're up to date than to not have that data. And I just wonder, do these registries allow for patient

reported data, can they put it in, and what – does it have a flag on it that says it's a patient reported data because I would want to do it like that just to have it there but just to note that it was patient reported.

Female: I'm sure this has to do – it's decided at a local level and how these registry work flows.

Male: Yes.

Female: But our particular policy is we do accept patient reports. The data must go to the provider so the provider must accept that that report is legitimate, that that provider accepts so that it goes into the registry as historical and it's an accepted immunization. So, we don't let patients put it in and say, "Oh, yes, I'm immunized." The patient tells the provider, "I am immunized," the provider accepts that, meaning they believe it, then that data comes into our registry and sort of accepted …

Male: So, you send a form to the provider and ask them to fill out the form, right?

Female: No, it's all electronically transmitted. We're connected to the EHR.

Male: Or just that do you agree with this or something?

Male: I'm just wasn't sure.

Female: If the provider accepts that they got an MMR at the age 1 year …

Male: It kind of just go check …

Female: … it goes into their record. They have to put it into their record. If it's not good enough for their own electronic health record, it's not good enough for my record. So, they put it in to their record, it comes into ours. And I think the codes may recognize that it is a historical event, that sort of a technical question I don't recall, but, yes, we do accept it and, yes, we do recognize the historical …

Female: So, when you say that the provider accepts it, you don't necessarily mean that they're validating it against their own records? They could just think that the

patient is believable and they arbitrarily – they and their judgment (inaudible) judgment for every patient.

Female: … kind of whatever that provider decides. But if it's good enough for their record, it's good enough for ours.

Male: So, what we've done practically in our practices, if somebody brings in a record from Indiana and we put that data into our EMR, that would go from the EMR into the state registry and would be recognized as, you know, whatever that data field says given in Indiana or given in, you know, I don't know exactly how that shows up but that's what it would look like.

Female: But that's a medical record, it's not a – you decided they were …

Male: … medical record and then it goes through the interface in the medical record (inaudible).

Male: But we actually in our practice will accept that the person is actually believable and you trust them. And they come and they said, "I was at Walgreens last month and I got it." We enter that into the record. And we pick a rough – they'll say it was October and we'll pick October 1st at the date and it gets historical.

Female: Is that flu specific because I think this issue very different for annual influenza versus other vaccines.

Male: So, we do it for other vaccines too.

Female: Our work is exactly the same (inaudible) vaccine not just flu.

Female: Virginia is (inaudible).

Male: What about a recommendation to the states that they need to have an adult registry. There's still three states that don't. And then if you have an adult registry, I agree that there should be a, you know, they should always be opted out. And I think then the second part of this would be the mandatory reporting I think – I think that's something that needs to be thought about.

Male: So, the – you're talking about (inaudible) with the mandatory part (inaudible) actually to make it (inaudible).

Male: I guess …

Male: I don't want to sound like I'm talking (inaudible) with my mouth here because I had the same recommendation for pharmacist, but I'm just thinking about like meaningful use and how this incentive program has – I don't know, there's debates of whether it's meaningful or useful. And that is at least the capability for the build out has been incentivized and that's what (inaudible) uptake of a lot of the HR components and I want to appreciate and be a little cautious in our recommendation on that at least from the words (inaudible) perspective. Encourage and incentivize (inaudible) both requires an entirely different language. I'd say we shouldn't say it, but …

(Crosstalk)

Male: … going to get the meaningful use, (inaudible), you know, you have to – I mean, that, you know, they require. It requires that interface that actually works and it's used …

Male: Sure, but meaningful use and incentive is …

Male: Well now, 2016 …

Male: Then it switches the sticks, right? But – so it's – I guess …

(Crosstalk)

Male: … smaller and the stick is getting – it (inaudible).

Female: Just to go quickly back to (LJ's) comment, we did talk about sort of the earlier structural thing and we might have to get our numbers and bullet points, but I think the thought was most date already have (life) and registries and most of them are already opted out results that we are kind of thinking that's there and now we need to push further to get people to use it as our (inaudible).

Male: So, that someone actually is doing on many projects on (inaudible), Minnesota being one that we surveyed. So, we're actually going and doing surveyed focus groups on with the registry runners and finding off some data. And Minnesota has an incredible outreach (inaudible) every hours we have. And you've got 45 percent of reports (inaudible). You have a 55 (inaudible).

(Off-mike)

Female: Yes, and I think you're right. And one of the problems that we run into is data quality. So, you know, our saturation of adults is more than our adult population. And it's because, you know, that person is getting a flu shot every year but their providers are not entering it in a consistent ways. So, (John Smith) got a flu shot in Minneapolis. He lives in St. Paul, but the provider entered that it was in Minneapolis. We get to next year, they enter (John Smith) St. Paul, it's two records.

And so, there's a lot data issues around adults, but I agree that outreach, we've done a lot of it but we're not there yet.

Female: And I think we should add to that point because I'm contractually obligated to plug the CDC standards once again, but there's another one that include a standard of the IIS being able to recognize and eliminate duplicative records that that might be another one that we want to pull out specifically because that's definitely an issue that we discuss also and it sounds like it came up in a nontraditional provider group too.

Female: It sounds like the fundamental question is, do we go with encourage and incentivize or do you want to punch it up to require?

(Off-mike)

Male: That was just me. I was just questioning whether or not …

Female: Well, what would be the mechanism because I think for pediatrics, there's a lot of, you know, with (BFC), there's a big program that we have that we can make people do something and there's not really an equivalent for adult unless

I think we may have talked about of Medicare of CMS decided to require for Medicare and Medicaid.

Male: It would require statutory change to make – (inaudible) is statutory. They can change the language and legislations …

(Off-mike)

Female: We are allowed to collect the data (inaudible) health services, but it's not – you don't have to a base statute that you have to enter. And I feel like it would be really hard of us to get that through a legislature. It's not one of the health departments' legislative priorities. However, if it were a CDC recommendation and just recommendation, I feel like that would have more (teeth).

Male: I think ultimately where we want to land at some point is the requirements. And how we get to that requirement could follow the same pathway as the meaningful use from loading up to the big stick. But I don't think there's anything wrong with starting with incentives and moving in that direction. It's – I guess it's not up to the script to determining the mechanism for it but the recommendation for eventual requirements or ramp up towards requirements is I think would be appropriate.

Male: I'd take my educator's view that I encourage, I encourage and I'll simply (inaudible). You ultimately are going to get it for us.

Male: Yes. Yes. Somebody is going to be (inaudible) on this point, like the laggards are definitely out there, three states without an IIS, that's the problem.

(Off-mike)

Male: Yes, Sorry.

Female: So, are there enough people that, you know, comfortable changing it to require or you more comfortable leaving at where it is?

(Off-mike)

Female: Yes.

(Off-mike)

Female: Kind of a mixed bag. We need to just kind of see where everybody stands. How many would want to change it to require. Obviously, the alternative is to leave it where it is. One – yes, require – two, three, four, five, six, seven, eight, nine. OK. And how many were there? One, two – how many leave it like it is?

(Off-mike)

Female: Yes – no, you're right. Yes, there might be some standards, so leave it as it is, encourage and incentivize, one, two, three, four, five. There you go, six. Well, nine to six. I mean, it's …

Male: So, I guess, just that for – as a proposal for the alternative, it's like create encouragement and incentive programs that lead to eventual requirement? Maybe that's too wordy, but …

Male: I have another split the difference, incentivize and consider mandating.

(Off-mike)

Male: Yes.

(Off-mike)

Female: All right.

(Off-mike)

Female: All right.

(Off-mike)

Jeffrey Duchin: If you're telling this, I will vote for leave it as it is. This is Jeff.

Female: OK, that becomes another seven. You guys are almost split. So, it is a tough one. But we can leave it that way. I mean, we could talk about the fact – the need to do it and, you know, that there really was different opinion around, you know, at what point it should become required, but certainly any opportunities for, you know, incentivizing and pushing participation and sees (inaudible), see if we can come up with better words.

Anything else in this particular topic area or set of recommendations? I just want to welcome (Jill) who join us again. So, these guys are have worked very hard for another stressing day.

(Off-mike)

Female: So at this point I don't have anything more the question I guess I would ask any of you is you sent two days talking about everything has to talk about measuring adult immunization is there anything we forgot, anything we didn't talk about?

Male: (Inaudible).

Female: Probably but I mean was there something burning you were just waiting for it to pop up on the agenda that never happened.

Male: I was just going to say it wasn't explicit identified as a measure gap I wonder if where the new Pneumococcal world is going with two vaccines really means that even though we have a bunch of new Pneumococcal measures they may not be appropriate to the world we're entering. So should that be thought off or I realize that's a real can of worms. So forget that but …

Male: (Inaudible) protracted conversation about this, I would say …

Female: I'll say if I had one too.

Male: Would you mind kind of informing the group.

(Off-mike)

Male: No you just talk about how there, I mean that inside of IQR the in-patient quality reporting this is (inaudible) /Pneumo vac. ACIP identified evidence preferred administration issue.

Male: OK, I'll be happy to do this but we spend a lot time talking about this at dinner too so I don't want, but and I think Roger voices this a better when we have two beers and (inaudible). Well certainly a lot more fun and …

Male: From this meeting is two beers …

Male: So simply I thought his comments were much more sparkling with the two beers.

Female: Should we adjourn to a bar to discuss this issue further?

Male: Maybe you should go and take …

Male: They like it …

(Crosstalk)

Male: Person who drink that says is that talk about the next day.

Male: Yes, we should …

Male: So what's happening with Pneumococcal our measure there out there right now. That there's a lot groups going in and it went every time something comes up a comment. Groups are coming in and they've conflicted because of the fact that most of these measure actually are generalized in that. When CMS clarified that when then say pneumococcal vaccine they mean even pneumococcal vaccine.

That even with the ACIP recommendations for use of (inaudible) first before PPV-23. The measure cover that you allow to do that and that's what the measure should be doing. You shouldn't be using measure to change to enforce an ACIP recommendation right. So a lot of people are happy with that and but there also a some number of people who feel that drives negative behavior and think that's absolutely true too.

I mean know because if I have more PPV-23 and in refrigerator and I need to be measure and I want to get rid of that stuff I'm going to use PPV-23 quickly because that's where I'm going. And even though that may not be the best thing out there based on the HIP recommendation. So there's concern that it drives negative behavior and their people will then say what we need to do is even terminate the measure or also spend the measure and that's kind of where we are right now with Pneumococcal is that there's a lot of confusion among how to measure this and in fact the IQR was suspended.

But I would note it was suspended when first thing they'll be taken off because the fact that there was a lot of (inaudible) you just can't discontinue this measurement it's extremely valuable. And so they suspended it with no timeframe. So there's a lot of (inaudible) regarding Pneumococcal vaccination requirement.

And think they'll be continued (inaudible) about and I think that's kind of that's a long discussion we had on, you know, where do we go from here.

Male: And the other thing that you and I discussed that I thought was really interesting is just a longest notion of requirements for our creating measures that drives ACIP guideline conformity among practitioners. Are there other options out there and use of the so that answer question is no. That there's really the main issue is between from (inaudible).

Litjen Tan: So are there other situations where this kind of controversy or it will arise again. And right now in the absence of any preferential recommendation for a flu or (inaudible) numbers PPV at this point. And this is the only situation where we're having this lack of conformity. And I know even consider it that because again I state the measures out there are broad enough to encompass giving (inaudible) 13 first followed by PPV 23.

And so kind of, you know.

Female: So L.J. you are saying it's not a measure problem at this point it's an implementation.

Litjen Tan: Exactly.

Female: Problem.

Litjen Tan: And but people so I don't know why people think we split on this I personally believe that what it is but there some people who are very strongly believe the measure should try to drive the ACIP recommendation and they're very vocal about that as well.

Male: I mean think every time practice changes we will get in the circumstance for this is. I mean we could face it with influenza, you know, where do you give high versus standard those vaccine and we really shouldn't be having be stuck changing our measures every time practice changes. Because then you have to go back and revalidate that measure. And that's five years on the line. So it just doesn't make sense to be specific.

Female: Correct on that what else I thought (inaudible) that was and it's kind of the reverse of the driving bad behavior I though there was also some concern about people want to do it the right way and follow the ACIP to a vaccination recommendations for your people in the risk groups. But we're concerned that they would be I don't know enable to get the vaccines why, enable to track it correctly and enable to implement this recommendation because they're new and they'll don't get thing turn out if their measure on it.

Litjen Tan: Vacation process because CMS have clarified that when you say Pneumococcal it's either. So when they say receive of Pneumococcal vaccine the expect you could do it for ACIP and it was either (inaudible) 13 or PPV-23 you're fully credit for completing the measurement. And I think that's my point and that's what I agree with. But I think there are folks who think that it should be more specific and I don't think you can.

Male: You know for another side, so I …

Litjen Tan: Drink a couple of beer.

Male: So what is the purpose of a measure? The purpose of a measure is to increase immunization and it's always to increase appropriate immunization. We're not

giving flu recommendations so that we give the wrong flu shot to people or giving them. So we always give the right flu shot to people and there is a tremendous amount of confusion about Pneumococcal vaccines right and a measure to measure it could be very helpful both in seeing how we're doing with it but also in educating a providers as to what is the correct way to do it.

So I certainly that there could be a rule for it, I don't think there has to be a rule for it. I agree with everybody around the table because I'm such a jolly fellow. But I do see how a measure could be utilized and think that's the purpose of the measure from the beginning is to impact utilization in a positive way and that, so that's and this seems to me like a perfect situation for it where nobody knows what to do.

And then, you know, I mean the experts know what to do I agree that right now is that the right time because we're in a time of change and things may change very soon in the direction of towards the conjugated vaccine. So I would want to do it now but I do think we should be open to that in the future.

Male: And maybe that it could be a recommendation but, by just a purpose of the script is to identify a measure gaps but this is not a measure gap …

Female: If you (inaudible) at the existing measure no longer was useful then it may have gap but that's not what I'm hearing from you.

Male: Right.

Male: Anywhere does say.

Male: the specifically cap, you know, polysaccharides or Pneumo vacs, well then it's a gap. But I don't probably …

(Off-mike)

Male: I think Pneumococcal vaccine (inaudible).

Male: I mean what I doesn't say anything about, you know, so another measure could simply be the booster dose.

Male: And say it's one of the reasons I raise it is over the last couple of years I've seen this (inaudible) we know that the Pneumococcal measure was removed from the five star measure set we have the Pneumococcal measure now suspended in the hospital program so I worry overall about what seems to be kind of moving backwards Pneumococcal has been one of the core vaccine has been measured and while the measures have been removed or suspended I haven't seen a level of activity like this that would envision where things are going for Pneumococcal measure.

So I worry if it's not addressed that you could be in this situation where you just continue with this confusion (inaudible).

(Off-mike)

Male: I think I said at beginning kind of got lost is that I think right now that this limbo, you know, where the IQR measure suspended others have been terminated people that you can't just do that but there's no time frame. I mean there's no timeframe when what this means. So but they could I want to just can be just ready (inaudible)

Male: Right, right.

Female: do you want …

Male: recommendations to settle.

Female: Do you want to say anything or the thing just came to much and (inaudible) said there's anything today.

Male: I think there is something to say about it. And I mean we spend a lot of time talking about the need for harmonization and consolidation and I suppose when we're talking about things that we do and don't know when we're trying to prioritize our gaps about what would be important will this one area where we know that this is super important this 900,000 people we get Pneumonia every year half of them get hospitalized by the 7 percent of them die. So our measures working as well as we (inaudible).

Female: The question is if there is a measure gap where we need to develop a measure. That's my point.

Male: Probably not.

Male: there is a measured gap but we're not at the point where things are stable enough that we need to develop a measure.

Male: Pretty close.

Male: I mean that would be my recommendation.

Male: we're pretty close and I think that we could use the hepatitis B as a particular, you know, hepatitis B we don't say where did they get one dose and the measure let say well did they get one dose it kind of follow away. And so this, you know, maybe a two dose series now so maybe, you know, simple thing like that did you get you full series of Pneumococcal vaccines. So I don't think it's undoable it's definitely it should change and we can't continue to say one is definitely have to change because it's going to be different recommendation more of a different dosage, different people …

Female: The IQR measure is an NQF endorse measure it will come up for many interview probably next year. So perhaps that timing …

Male: I think it's a good timing. And I think right now I just want to clarify and make it very clear that right now the only ACIP recommendation in terms deferential use of causing the problems is for you to compromise people. (inaudible) 13 is recommended ahead of PPV-23 otherwise the ACIP has no other preferential distinctive recommendation with (inaudible) is causing the issue. Now at the (inaudible) that may change but we don't know that. I mean right now that ACIP is court.

Female: Well I do think that the issue with Pneumococcal particularly that there are two different vaccines and this one population there's not only preference but I think they're going to suppose to get them both a certain order at a certain age (inaudible).

Male: That's only in the compromise.

Female: Right but I think if anything are recommendation would be the immunization quality measure should be diagnostic as to dioxin type. Because, you know, what freak off form HPV4 to HPV9 and ACIP mix recommendation would say preferentially recommend quadrivalent versus trivalent influenza vaccine or high dose versus standard dose influenza vaccine to people and yes you don't want to spend five year to revalidating the measure because it had the wrong word in it.

Male: So that (inaudible) fact to exactly what we started out saying we just Pneumococcal vaccine has (inaudible) means Pneumococcal vaccine no preference.

Female: Actually (inaudible) hearing something that would have a big impact on measurement in general across all of vaccinations and that is not to over specify based on today's name of the vaccine because as that, you know, as it evolves, you want – you don't want to have to keep changing the measure. And so, that seems like that could apply to not just pneumococcal but across the board …

(Crosstalk)

Male: … than that though. You can't just say, you can't do that. You have to say – you have so specify which comes first, you have to, and it's very important that you do. You don't have to give a brand name but you have to say the cons you get comments before this whole (inaudible) because otherwise you could damage the immune response. And I think that needs to be known and should be put out. I mean, that seems like a huge issue.

Male: But that's not a – I honestly believe that's not a measurement issue because, you know what, Roger, you want – we are talking about reducing the number of measures, right? So, if you did that and let's say ACIP and this is not done yet or may not ever be done, but let's say (inaudible) becomes one of the preferential recommendation for LAIV. (inaudible) recommendation with high dose (Sanofi), are we going to create a measure for each one of those so that we can push the appropriate use of those vaccines? I don't think we will.

That's not appropriate. That's not what measurements for. It's for us to implement the measurement saying, if you've got a 65 and older and the ACIP has voted to do this, this is what – this is the flu vaccine that will satisfy the measurement. That's my personal opinion.

Male: OK, but this is a different issue. So, this is a health issue and I do no harm issues, one that, you know …

Male: And also, I think that we have – I mean, there's a history of measures being taken up into – I mean, just to play, there was obviously (inaudible). There's a history of using measures to drive appropriate behaviors, for example. I mean, we're reconsidering the measure itself, but right now inside of Medicare Part B, we have a measure for appropriate use of (inaudible) in patients with diabetes. So, like if they have hypertension, we use the correct drug because of the renal protective property. So, that's really just following practice guidelines so shall we not be encouraging following …

(Crosstalk)

Male: … I would hope everyone is following ACIP recommendations, but as we noted, there are – how many – 70 something ACIP recommendations for vaccines, so you need t a measurement for each one of those to drive the ACIP recommendation, the answer is no. What you're trying to measure is did this person over 65 get influenza vaccine, and if by chance someone says – ACIP says it's going to be high dose, then you – that's what you need to go out and implement it if that's the guideline.

I don't think measures are meant to drive adherence to guidelines. I don't think measures are meant to drive guidelines use. I think measures are meant to measure. And if the person got a flu vaccine, that's what you measure. I mean, as well as you're going to have – you're going to have a measure for every single component that …

Male: But measurement is not the end of measure. This is – it's not why we're here, otherwise, we would just be bored, you know.

Female: Conversation is getting very …

(Crosstalk)

Male: … we should. I'm saying that I think that one of the purposes of measurement – the overwhelming purpose is to increase appropriate immunization. And as a part of that is education and a lot, but I don't think this is the appropriate form, we're not going to come up with that here and I'm fine with that. And there's going to be other groups that do all those stuff anyway. But if I sit on it and I know …

Male: The goal of the measurement is to prevent vaccine preventable illness, vaccine preventable disability. And the way we do that for influenza is we recommend that you follow the appropriate guidelines. So, it's really – the end all is not the vaccine. The end all is the prevention of illness and disease. And we do that based on established standards of care, et cetera. So, that's where I think, you know, I agree with (LJ) on this, so.

Male: Sure, but, I mean, this is going to be great to a wrestling match …

(Crosstalk)

Female: It's too nice – hey guys.

(Off-mike)

Female: It's –yes. It's too nice today.

Male: So, we're …

Female: You have sunshine.

Male: I don't think in any of this adversary. Well, I think this is an interesting …

(Off-mike)

Male: No, we're like BFF now. We're going to be friends in Facebook (inaudible). I guess, if we're talking about this in terms of process measures, boiled down to how granular, do you want to get in your process.

Female: Yes.

Male: So, I mean, it is – you're right. The ultimate goal is the prevention of disease and determine the best methodology for it. And – but I think it's – I can see both sides and I'm OK with us remaining silent on the issue, but – and maybe (inaudible).

(Off-mike)

Male: In my own devil's advocate, the one place where I would say the value in this would be would be you need data collection to – on specificity of the vaccine being used. You know, and that I think – that I think where it's – there will be value there. But I think then you evaluate and you, you know, you kind of take a look at that on case by case scenario.

Female: I was going to kind of say the same thing (LJ). Maybe this is – you'll talk so much about the data we collect and maybe this is something, you know, we look back and evaluate how were the measures followed, you know, did PCV come before PPSV, that kind of thing. And it looks like we're kind of setting ourselves up to have that kind of rich data to be able to evaluate practice that way too.

It's a really good point. So, at this point, you know, what we could say is that if – for a pneumococcal – anything pneumococcal, we just want to make sure you'd capture – you don't want to just say they just got a pneumococcal shot. We want to know what they got.

Female: But – and basically, I mean, I – and to clarify, I completely see your point now. You're talking about is there a measure gap for measurement of pneumococcal vaccination among immunocompromised people based on this change in practice. And that I think is a little different. But what I was saying is in general, when your (inaudible), that's fine population measures or even provider measures for the general adult population. They should be agnostic as possible to the formulation of the vaccine just as soon, yes, that the provider is going to follow standard of care (inaudible) whatever it is they feel.

But, yes, I mean, if you were to say, well, there's a real problem here doing this vaccination correctly in the immunocompromised, then obviously one of which different measure.

Jeffrey Duchin: This is Jeff. I've been following this conversation with great interest. We're currently working on pneumococcal workgroup for ACIP and I also practice adult medicine and it's a very complicated vaccine from the provider perspective both in the context of the formulations available and the variety of different recommendations based on prior immunization history and a variety of underlying chronic and immunocompromising conditions.

So, I agree that ideally we want to measure the appropriate use of this vaccine not just the fact that someone's got record of the pneumococcal vaccine in their medical record. But I think it's, you know, it take a lot of time and thoughtful work to come up with measures that are relatively realistic and meaningful. Yes, I'm not sure that we can do that today, but I very much support the measurement of some measure of compliance with pneumococcal vaccination recommendations and I hope that we can work to persuade relevant experts to come up with that measure independent of our discussion today.

Male: Sounds good. To put this one off to another (then).

Female: Do you want to open up last time for public comments?

(Off-mike)

Reva Winkler: … out there. Operator, is there anybody out there who wants to make a public comment?

Operator: If you'd like to make a public comment at this time, please press star then the number 1.

There are no public comments at this time.

Reva Winkler: Thank you.

OK. Thanks for two terrific days. Juliet is going to give you a couple of last next step kind of where we go from here along the timeline. We will be communicating virtually going forward. This is our only face to face encounter. So, it really has been fun, you know, meeting you and having the opportunity to engage personally. And so, I've really enjoyed it.

And as typical for committees going forward, I've just made a lot of new friends. So, don't ever hesitate to get in touch if there's anything I can do here via NQF or anything else. I always really enjoy hearing from folks on past committees in whatever is happening. But we will be communicating as we go forward. So, Juliet will tell you what the next steps are. But for me, thanks so much.

Juliet Feldman: So, very briefly, as we are relayed yesterday, the next steps is that we are going to draft a report based on the committee's deliberations these past two days. The draft report is due to HHS on June 15th. We'll be having a public webinar on June 26th for the public to comment on the draft report. And the final report will be due to HHS on August 15th.

And as Reva has mentioned, we will circulate the draft report to the committee before it's posted for public comments so we can all be good with what is said in the report. And we will also be in touch regarding your reimbursement, so please look out for an e-mail from either me or NQF meetings.

And, yes, just want to thank you all again for being here. It's been a pleasure.

Male: Yes, I was just going to say, we'd be remised with – of not thanking our two co-chairs and the NQF staff for doing an amazing job and facilitating this. I don't think the conversation would be as nearly as good as it was without you guys. So, thank you.

Male: Yes, I'd like to thank you for allowing me to participate by phone. And I apologize for any (inaudible) or other socially inappropriate comments.

(Off-mike)

Female: Enjoy being in the park.

Male: Thank you. I'm getting a little sunburn and I think I should go now.

Female: … you'd like to close the call.

Operator: OK. This concludes today's conference call. You may now disconnect.

END